

105TH CONGRESS  
1ST SESSION

# S. 386

To amend title XVIII of the Social Security Act to protect and improve the medicare program, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

MARCH 3, 1997

Mr. WYDEN introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to protect and improve the medicare program, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; DEFINI-**  
4       **TION OF SECRETARY.**

5       (a) SHORT TITLE.—This Act may be cited as the  
6       “Medicare Modernization and Patient Protection Act of  
7       1997”.

8       (b) TABLE OF CONTENTS.—The table of contents of  
9       this Act is as follows:

Sec. 1. Short title; table of contents; definition of Secretary.  
Sec. 2. Findings.

## TITLE I—PROMOTING COMPETITION, QUALITY, AND BENEFICIARY CHOICE IN MEDICARE

- Sec. 101. Establishment of plan improvement and competition office.
- Sec. 102. HMO competitive pricing demonstration projects.
- Sec. 103. Medigap amendments.

## TITLE II—INCREASING MEDICARE COVERAGE OPTIONS

### Subtitle A—Risk Plan Improvements

- Sec. 201. Financing and quality modernization and reform.
- Sec. 202. Quality report cards and comparative reports.
- Sec. 203. Preemption of State laws restricting managed care.
- Sec. 204. Appeals.
- Sec. 205. Medicare HMO enrollment fair.

### Subtitle B—Maintaining Fee-for-Service Program

- Sec. 211. Failsafe budget mechanism.
- Sec. 212. Maintenance of part B premium at current percentage of part B program costs.

## TITLE III—PROMOTION OF PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) AND OF SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS)

- Sec. 301. Definitions.
- Sec. 302. Expanding the availability of qualified organizations for frail elderly community projects (Program of All-Inclusive Care for the Elderly (PACE)).
- Sec. 303. Application of spousal impoverishment rules.
- Sec. 304. Permitting expansion and making permanent SHMO waivers.
- Sec. 305. Repeals; effective date.

## TITLE IV—OTHER MEDICARE CHANGES

- Sec. 401. Application of competitive acquisition process for part B items and services.
- Sec. 402. Simpler procedure for inherent reasonableness determinations.
- Sec. 403. Promoting advance directives.
- Sec. 404. Antifraud efforts.
- Sec. 405. Hospice benefits.
- Sec. 406. Study providing pharmacy services to medicare beneficiaries.
- Sec. 407. Respite benefit.

## TITLE V—PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

- Sec. 501. Payment for home health services.
- Sec. 502. Review by peer review organization of home health services.
- Sec. 503. Retroactive reinstatement of presumptive waiver of liability.

## TITLE VI—PROSPECTIVE PAYMENT SYSTEM FOR NURSING FACILITIES

- Sec. 601. Definitions.
- Sec. 602. Payment objectives.
- Sec. 603. Powers and duties of the Secretary.

- Sec. 604. Relationship to title XVIII of the Social Security Act.
- Sec. 605. Establishment of resident classification system.
- Sec. 606. Cost centers for nursing facility payment.
- Sec. 607. Resident assessment.
- Sec. 608. The per diem rate for nursing service costs.
- Sec. 609. The per diem rate for administrative and general costs.
- Sec. 610. Payment for fee-for-service ancillary services.
- Sec. 611. Reimbursement of selected ancillary services and other costs.
- Sec. 612. Per diem payment for property costs.
- Sec. 613. Mid-year rate adjustments.
- Sec. 614. Exception to payment methods for new and low volume nursing facilities.
- Sec. 615. Appeal procedures.
- Sec. 616. Transition period.
- Sec. 617. Effective date; inconsistent provisions.

#### TITLE VII—TELEMEDICINE

- Sec. 701. Internet access for health care providers for rural areas.
- Sec. 702. Commission on telemedicine.

1       (c) DEFINITION OF SECRETARY.—As used in this  
 2 Act, the term “Secretary” means the Secretary of Health  
 3 and Human Services.

#### 4 **SEC. 2. FINDINGS.**

5       Congress makes the following findings:

6           (1) It is in the interest of both taxpayers and  
 7 beneficiaries under the medicare program under title  
 8 XVIII of the Social Security Act (42 U.S.C. 1395 et  
 9 seq.) that the program provide those beneficiaries  
 10 with a broad array of health plan choices and gen-  
 11 erally encourage competition between providers to  
 12 promote lower costs and greater variety among plans  
 13 offered by eligible organizations under section 1876  
 14 of that Act (42 U.S.C. 1395mm).

15           (2) Such competition and consumer choice is  
 16 consistent with a guaranteed defined package of

1        basic health care service benefits, including ready ac-  
2        cess to physicians and other health care providers,  
3        hospitalization and home care services, and a com-  
4        prehensive system of preventive care options.

5            (3) As the medicare program evolves into a pro-  
6        gram offering beneficiaries more choices, it is critical  
7        that those beneficiaries have more definitive and  
8        more easily comparable information about plans of-  
9        fered by eligible organizations under section 1876 of  
10       that Act, and that those beneficiaries are protected  
11       against adverse coverage decisions under the medi-  
12       care program through a strengthened grievance and  
13       appeals process.

14           (4) Establishing stronger fiscal integrity in the  
15       medicare program will involve—

16            (A) eliminating unnecessary and wasteful  
17        geographic variability within the medicare pro-  
18        gram's national reimbursement system;

19            (B) establishing stronger antifraud provi-  
20        sions including enhanced criminal penalties for  
21        practitioners and entities involved in medicare  
22        billing abuses; and

1 (C) establishing “smart shopper” man-  
2 dates that require the medicare program to de-  
3 mand competitive bidding and prospective pay-  
4 ment on goods and services purchased by the  
5 program for beneficiaries.

6 (5) The medicare program must accommodate  
7 its reimbursement system to a variety of alternative  
8 and creative health care systems and providers such  
9 as telemedicine, hospice care, and medical care serv-  
10 ices from the nonphysician licensed professions, as it  
11 has been shown that such systems offer beneficiaries  
12 under the medicare program services which are as  
13 good or better than those offered by traditional prac-  
14 titioners and may save taxpayer dollars.

15 (6) The frail elderly eligible under both the  
16 medicare program and the medicaid program under  
17 title XIX of that Act (42 U.S.C. 1396 et seq.) are  
18 among the fastest growing and most costly segments  
19 of the medicare population. It is in the interest of  
20 both the taxpayer and these beneficiaries that the  
21 medicare program encourage and nurture the On-  
22 Lok program, Social Health Maintenance Organiza-  
23 tions, and PACE (under title III of this Act) which

1 have been designed specifically to serve this popu-  
 2 lation in a humane, effective, and cost-efficient man-  
 3 ner.

4 **TITLE I—PROMOTING COMPETI-**  
 5 **TION, QUALITY, AND BENE-**  
 6 **FICIARY CHOICE IN MEDI-**  
 7 **CARE**

8 **SEC. 101. ESTABLISHMENT OF PLAN IMPROVEMENT AND**  
 9 **COMPETITION OFFICE.**

10 (a) ESTABLISHMENT.—Not later than January 1,  
 11 1998, the Secretary shall establish the Office of Plan Im-  
 12 provement and Competition (in this title referred to as the  
 13 “Office”) within the Health Care Financing Administra-  
 14 tion.

15 (b) DUTIES.—The duties of the Office shall include  
 16 the following:

17 (1) To collect data from the Social Security Ad-  
 18 ministration’s regional offices regarding the system-  
 19 atic coverage and procedural inconsistencies in the  
 20 determination by intermediaries, carriers, and health  
 21 maintenance organizations under the medicare pro-  
 22 gram as to whether an item or service is covered or  
 23 disallowed in full or in part.

24 (2) To supervise and monitor advertising and  
 25 promotional materials distributed to individuals by

1 eligible organizations under section 1876 of the So-  
2 cial Security Act (42 U.S.C. 1395mm) and by orga-  
3 nizations which provide medicare supplemental poli-  
4 cies under section 1882 of that Act (42 U.S.C.  
5 1395ss) in order to ensure that the information con-  
6 tained in such materials is accurate and enable the  
7 individuals receiving the materials to compare the  
8 organizations that the individuals are eligible to en-  
9 roll with.

10 (3) To collect data regarding the results of re-  
11 search by organizations on improvement in health  
12 care quality and best-practice information.

13 (4) To distribute the data collected under para-  
14 graph (3) to eligible organizations under section  
15 1876 of the Social Security Act (42 U.S.C.  
16 1395mm) and by organizations which provide medi-  
17 care supplemental policies under section 1882 of  
18 that Act (42 U.S.C. 1395ss), and to encourage such  
19 organizations to incorporate the results of that re-  
20 search in the plans offered by the organizations to  
21 individuals.

22 (5) To publish and distribute the quality report  
23 cards and the comparative reports developed by the  
24 Secretary under section 1805 of the Social Security  
25 Act, as added by section 202 of this Act.

1 **SEC. 102. HMO COMPETITIVE PRICING DEMONSTRATION**  
 2 **PROJECTS.**

3 (a) DEMONSTRATION PROJECTS.—

4 (1) IN GENERAL.—The Secretary shall conduct  
 5 demonstration projects in every applicable area, as  
 6 defined in paragraph (2), for the purpose of estab-  
 7 lishing competitive pricing for eligible organizations  
 8 with risk-sharing contracts under section 1876 of  
 9 the Social Security Act (42 U.S.C. 1395mm).

10 (2) APPLICABLE AREA DEFINED.—

11 (A) IN GENERAL.—In paragraph (1), the  
 12 term “applicable area” means a medicare pay-  
 13 ment area—

14 (i) that has an input-price-adjusted  
 15 national adjusted average per capita cost  
 16 that is at least 120 percent of the national  
 17 standardized adjusted average per capita  
 18 cost, determined under section  
 19 1876(a)(4)(D)(ii) of the Social Security  
 20 Act (42 U.S.C. 1395mm(a)(4)(D)(ii)), as  
 21 added by section 201 of this Act; or

22 (ii) where at least 50 percent of the  
 23 eligible organizations under section 1876  
 24 of the Social Security Act (42 U.S.C.  
 25 1395mm) in that area offer health plans



1           under that section with monthly premiums  
2           that are less than \$20.

3           If the Secretary determines that a medicare  
4           payment area is an applicable area under this  
5           section, that area shall continue to be an appli-  
6           cable area for the duration of the demonstra-  
7           tion projects conducted under this section.

8           (B) LIMITATION.—A medicare payment  
9           area shall not be considered an applicable area  
10          if the Secretary determines before starting the  
11          demonstration project in that area that there  
12          are an insufficient number of eligible organiza-  
13          tions with risk-sharing contracts under section  
14          1876 of the Social Security Act (42 U.S.C.  
15          1395mm) in that area to support a demonstra-  
16          tion project under this section.

17          (C) MEDICARE PAYMENT AREA; ADJUSTED  
18          AVERAGE PER CAPITA COST; INPUT-PRICE-AD-  
19          JUSTED NATIONAL ADJUSTED AVERAGE PER  
20          CAPITA COST.—In this section, the terms “med-  
21          icare payment area”, “adjusted average per  
22          capita cost”, and “input-price-adjusted national  
23          average per capita cost” have the meaning

1           given those terms in section 1876(a) of the So-  
 2           cial Security Act (42 U.S.C. 1395mm(a)), as  
 3           added by section 201 of this Act.

4           (3) LIMITATION OF PAYMENT.—The Secretary  
 5           shall not make a payment to an eligible organization  
 6           under a demonstration project conducted under this  
 7           section that is greater than the payment that would  
 8           have been made to that organization under section  
 9           1876 of the Social Security Act (42 U.S.C.  
 10          1395mm) if not for the demonstration project.

11          (4) REQUIREMENT OF NUMBER OF BIDS.—The  
 12          Secretary shall discontinue the demonstration  
 13          project conducted under this section in a medicare  
 14          payment area where only 1 eligible organization with  
 15          risk-sharing contracts under section 1876 of the So-  
 16          cial Security Act (42 U.S.C. 1395mm) submits a bid  
 17          to the Secretary to provide items and services under  
 18          the demonstration project.

19          (b) REPORT TO CONGRESS.—

20           (1) IN GENERAL.—Not later than January 1,  
 21           2002, the Secretary shall submit to Congress a re-  
 22           port regarding the demonstration projects conducted  
 23           under this section.

24           (2) CONTENTS OF REPORT.—The report de-  
 25           scribed in paragraph (1) shall include the following:

1 (A) A description of the demonstration  
2 projects conducted under this section.

3 (B) Recommendations for establishing a  
4 new payment methodology for eligible organiza-  
5 tions with risk-sharing contracts under section  
6 1876 of the Social Security Act (42 U.S.C.  
7 1395mm), based on the results of the dem-  
8 onstration projects conducted under this sec-  
9 tion.

10 (C) Any other information regarding the  
11 demonstration projects conducted under this  
12 section that the Secretary determines would as-  
13 sist Congress in revising a new payment meth-  
14 odology for eligible organizations with risk-shar-  
15 ing contracts under section 1876 of that Act  
16 (42 U.S.C. 1395mm).

17 (c) WAIVER OF MEDICARE REQUIREMENTS.—The  
18 Secretary shall waive compliance with the requirements of  
19 title XVIII of the Social Security Act (42 U.S.C. 1395  
20 et seq.) to such extent and for such period as the Secretary  
21 determines is necessary to conduct demonstration projects  
22 under this section.

23 (d) NO ADDITIONAL FUNDING.—The Secretary shall  
24 conduct demonstration projects under this section with  
25 funds otherwise available to the Secretary.

1 **SEC. 103. MEDIGAP AMENDMENTS.**

2 (a) GUARANTEEING ISSUE WITHOUT PREEXISTING  
 3 CONDITIONS FOR CONTINUOUSLY COVERED INDIVID-  
 4 UALS.—Section 1882(s) of the Social Security Act (42  
 5 U.S.C. 1395ss(s)) is amended—

6 (1) in paragraph (3), by striking “paragraphs  
 7 (1) and (2)” and inserting “this subsection”,

8 (2) by redesignating paragraph (3) as para-  
 9 graph (4), and

10 (3) by inserting after paragraph (2) the follow-  
 11 ing:

12 “(3)(A) The issuer of a medicare supplemental pol-  
 13 icy—

14 “(i) may not deny or condition the issuance or  
 15 effectiveness of a medicare supplemental policy de-  
 16 scribed in subparagraph (C);

17 “(ii) may not discriminate in the pricing of the  
 18 policy on the basis of the individual’s health status,  
 19 medical condition (including both physical and men-  
 20 tal illnesses), claims experience, receipt of health  
 21 care, medical history, genetic information, evidence  
 22 of insurability (including conditions arising out of  
 23 acts of domestic violence), age, or disability; and

24 “(iii) may not impose an exclusion of benefits  
 25 based on a pre-existing condition,

1 in the case of an individual described in subparagraph (B)  
2 who seeks to enroll under the policy not later than 63 days  
3 after the date of the termination of enrollment described  
4 in such subparagraph.

5 “(B) An individual described in this subparagraph is  
6 an individual described in any of the following clauses:

7 “(i) The individual is enrolled with an eligible  
8 organization under a contract under section 1876 or  
9 with an organization under an agreement under sec-  
10 tion 1833(a)(1)(A) and such enrollment ceases ei-  
11 ther because the individual moves outside the service  
12 area of the organization under the contract or agree-  
13 ment or because of the termination or nonrenewal of  
14 the contract or agreement.

15 “(ii) The individual is enrolled with an organi-  
16 zation under a policy described in subsection (t) and  
17 such enrollment ceases either because the individual  
18 moves outside the service area of the organization  
19 under the policy, because of the bankruptcy or insol-  
20 vency of the insurer, or because the insurer closes  
21 the block of business to new enrollment.

22 “(iii) The individual is covered under a medi-  
23 care supplemental policy and such coverage is termi-  
24 nated because of the bankruptcy or insolvency of the  
25 insurer issuing the policy, because the insurer closes

1 the block of business to new enrollment, or because  
2 the individual changes residence so that the individ-  
3 ual no longer resides in a State in which the issuer  
4 of the policy is licensed.

5 “(iv) The individual is enrolled under an em-  
6 ployee welfare benefit plan that provides health ben-  
7 efits that supplement the benefits under this title  
8 and the plan terminates or ceases to provide (or sig-  
9 nificantly reduces) such supplemental health benefits  
10 to the individual.

11 “(v)(i) The individual is enrolled with an eligi-  
12 ble organization under a contract under section  
13 1876 or with an organization under an agreement  
14 under section 1833(a)(1)(A) and such enrollment is  
15 terminated by the enrollee during the first 12  
16 months of such enrollment, but only if the individual  
17 never was previously enrolled with an eligible organi-  
18 zation under a contract under section 1876 or with  
19 an organization under an agreement under section  
20 1833(a)(1)(A).

21 “(ii) The individual is enrolled under a policy  
22 described in subsection (t) and such enrollment is

1       terminated during the first 12 months of such en-  
2       rollment, but only if the individual never was pre-  
3       viously enrolled under such a policy under such sub-  
4       section.

5       “(C)(i) Subject to clause (ii), a medicare supple-  
6       mental policy described in this subparagraph, with respect  
7       to an individual described in subparagraph (B), is a policy  
8       the benefits under which are comparable or lesser in rela-  
9       tion to the benefits under the enrollment described in sub-  
10      paragraph (B) (or, in the case of an individual described  
11      in clause (ii), under the most recent medicare supple-  
12      mental policy described in clause (ii)(II)).

13      “(ii) An individual described in this clause is an indi-  
14      vidual who—

15              “(I) is described in subparagraph (B)(v), and

16              “(II) was enrolled in a medicare supplemental  
17      policy within the 63-day period before the enrollment  
18      described in such subparagraph.

19      “(iii) As a condition for approval of a State regu-  
20      latory program under subsection (b)(1) and for purposes  
21      of applying clause (i) to policies to be issued in the State,  
22      the regulatory program shall provide for the method of  
23      determining whether policy benefits are comparable or  
24      lesser in relation to other benefits. With respect to a State

1 without such an approved program, the Secretary shall es-  
 2 tablish such method.

3 “(D) At the time of an event described in subpara-  
 4 graph (B) because of which an individual ceases enroll-  
 5 ment or loses coverage or benefits under a contract or  
 6 agreement, policy, or plan, the organization that offers the  
 7 contract or agreement, the insurer offering the policy, or  
 8 the administrator of the plan, respectively, shall notify the  
 9 individual of the rights of the individual, and obligations  
 10 of issuers of medicare supplemental policies, under sub-  
 11 paragraph (A).”.

12 (b) LIMITATION ON IMPOSITION OF PREEXISTING  
 13 CONDITION EXCLUSION DURING INITIAL OPEN ENROLL-  
 14 MENT PERIOD.—Section 1882(s)(2)(B) of the Social Se-  
 15 curity Act (42 U.S.C. 1395ss(s)(2)(B)) is amended to  
 16 read as follows:

17 “(B) In the case of a policy issued during the 6-  
 18 month period described in subparagraph (A), the policy  
 19 may not exclude benefits based on a pre-existing condi-  
 20 tion.”.

21 (c) CLARIFYING THE NONDISCRIMINATION REQUIRE-  
 22 MENTS DURING THE 6-MONTH INITIAL ENROLLMENT  
 23 PERIOD.—Section 1882(s)(2)(A) of the Social Security  
 24 Act (42 U.S.C. 1395ss(s)(2)(A)) is amended to read as  
 25 follows:



1 “(2)(A)(i) In the case of an individual described in  
2 clause (ii), the issuer of a medicare supplemental policy—

3 “(I) may not deny or condition the issuance or  
4 effectiveness of a medicare supplemental policy, and

5 “(II) may not discriminate in the pricing of the  
6 policy on the basis of the individual’s health status,  
7 medical condition (including both physical and men-  
8 tal illnesses), claims experience, receipt of health  
9 care, medical history, genetic information, evidence  
10 of insurability (including conditions arising out of  
11 acts of domestic violence), age, or disability.

12 “(ii) An individual described in this clause is an indi-  
13 vidual for whom an application is submitted before the end  
14 of the 6-month period beginning with the first month as  
15 of the first day on which the individual is 65 years of age  
16 or older and is enrolled for benefits under part B.”.

17 (d) EXTENDING 6-MONTH INITIAL ENROLLMENT  
18 PERIOD TO NONELDERLY MEDICARE BENEFICIARIES.—  
19 Section 1882(s)(2)(A)(ii) of the Social Security Act (42  
20 U.S.C. 1395ss(s)(2)(A)) (as amended by subsection (c) of  
21 this Act) is amended by striking “is submitted” and all  
22 that follows and inserting the following: “is submitted—

23 “(I) before the end of the 6-month period be-  
24 ginning with the first month as of the first day on

1       which the individual is 65 years of age or older and  
 2       is enrolled for benefits under part B; and

3               “(II) for each time the individual becomes eligi-  
 4       ble for benefits under part A pursuant to section  
 5       226(b) or 226A and is enrolled for benefits under  
 6       part B, before the end of the 6-month period begin-  
 7       ning with the first month as of the first day on  
 8       which the individual is so eligible and so enrolled.”.

9       (e) EFFECTIVE DATES.—

10           (1) GUARANTEED ISSUE.—The amendment  
 11       made by subsection (a) shall take effect on July 1,  
 12       1998.

13           (2) LIMIT ON PREEXISTING CONDITION EXCLU-  
 14       SIONS.—The amendment made by subsection (b)  
 15       shall apply to policies issued on or after July 1,  
 16       1998.

17           (3) CLARIFICATION OF NONDISCRIMINATION  
 18       REQUIREMENTS.—The amendment made by sub-  
 19       section (c) shall apply to policies issued on or after  
 20       July 1, 1998.

21           (4) EXTENSION OF ENROLLMENT PERIOD TO  
 22       DISABLED INDIVIDUALS.—

23               (A) IN GENERAL.—The amendment made  
 24       by subsection (d) shall take effect on July 1,  
 25       1998.

1                   (B) TRANSITION RULE.—In the case of an  
 2                   individual who first became eligible for benefits  
 3                   under part A of title XVIII of the Social Secu-  
 4                   rity Act pursuant to section 226(b) or 226A of  
 5                   such Act and enrolled for benefits under part B  
 6                   of such title before July 1, 1998, the 6-month  
 7                   period described in section 1882(s)(2)(A) of  
 8                   such Act shall begin on July 1, 1998. Before  
 9                   July 1, 1998, the Secretary shall notify any in-  
 10                  dividual described in the previous sentence of  
 11                  their rights in connection with medicare supple-  
 12                  mental policies under section 1882 of such Act,  
 13                  by reason of the amendment made by sub-  
 14                  section (d).

15               (f) TRANSITION PROVISIONS.—

16               (1) IN GENERAL.—If the Secretary identifies a  
 17               State as requiring a change to its statutes or regula-  
 18               tions to conform its regulatory program to the  
 19               changes made by this section, the State regulatory  
 20               program shall not be considered to be out of compli-  
 21               ance with the requirements of section 1882 of the  
 22               Social Security Act due solely to failure to make  
 23               such change until the date specified in paragraph  
 24               (4).

1           (2) NAIC STANDARDS.—If, within 9 months  
2       after the date of enactment of this Act, the National  
3       Association of Insurance Commissioners (in this  
4       subsection referred to as the “NAIC”) modifies its  
5       NAIC Model Regulation relating to section 1882 of  
6       the Social Security Act (referred to in such section  
7       as the 1991 NAIC Model Regulation, as modified  
8       pursuant to section 171(m)(2) of the Social Security  
9       Act Amendments of 1994 (Public Law 103–432)  
10      and as modified pursuant to section  
11      1882(d)(3)(A)(vi)(IV) of the Social Security Act, as  
12      added by section 271(a) of the Health Care Port-  
13      ability and Accountability Act of 1996 (Public Law  
14      104–191) to conform to the amendments made by  
15      this section, such revised regulation incorporating  
16      the modifications shall be considered to be the appli-  
17      cable NAIC model regulation (including the revised  
18      NAIC model regulation and the 1991 NAIC Model  
19      Regulation) for the purposes of such section.

20           (3) SECRETARY STANDARDS.—If the NAIC  
21      does not make the modifications described in para-  
22      graph (2) within the period specified in such para-  
23      graph, the Secretary shall make the modifications

1 described in such paragraph and such revised regu-  
2 lation incorporating the modifications shall be con-  
3 sidered to be the appropriate regulation for the pur-  
4 poses of such section.

5 (4) DATE SPECIFIED.—

6 (A) IN GENERAL.—Subject to subpara-  
7 graph (B), the date specified in this paragraph  
8 for a State is the earlier of—

9 (i) the date the State changes its stat-  
10 utes or regulations to conform its regu-  
11 latory program to the changes made by  
12 this section, or

13 (ii) 1 year after the date the NAIC or  
14 the Secretary first makes the modifications  
15 under paragraph (2) or (3), respectively.

16 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
17 QUIRED.—In the case of a State which the Sec-  
18 retary identifies as—

19 (i) requiring State legislation (other  
20 than legislation appropriating funds) to  
21 conform its regulatory program to the  
22 changes made in this section, but

23 (ii) having a legislature which is not  
24 scheduled to meet in 1999 in a legislative

1 session in which such legislation may be  
 2 considered,  
 3 the date specified in this paragraph is the first  
 4 day of the first calendar quarter beginning after  
 5 the close of the first legislative session of the  
 6 State legislature that begins on or after July 1,  
 7 1999. For purposes of the previous sentence, in  
 8 the case of a State that has a 2-year legislative  
 9 session, each year of such session shall be  
 10 deemed to be a separate regular session of the  
 11 State legislature.

12 **TITLE II—INCREASING**  
 13 **MEDICARE COVERAGE OPTIONS**  
 14 **Subtitle A—Risk Plan**  
 15 **Improvements**

16 **SEC. 201. FINANCING AND QUALITY MODERNIZATION AND**  
 17 **REFORM.**

18 (a) PAYMENTS TO HEALTH MAINTENANCE ORGANI-  
 19 ZATIONS AND COMPETITIVE MEDICAL PLANS.—

20 (1) IN GENERAL.—Section 1876(a) of the So-  
 21 cial Security Act (42 U.S.C. 1395mm(a)) is amend-  
 22 ed to read as follows:

1       “(a)(1)(A) The Secretary shall annually determine,  
 2 and shall announce (in a manner intended to provide no-  
 3 tice to interested parties) not later than October 1 before  
 4 the calendar year concerned—

5               “(i) a per capita rate of payment for individuals  
 6 who are enrolled under this section with an eligible  
 7 organization which has entered into a risk-sharing  
 8 contract and who are entitled to benefits under part  
 9 A and enrolled under part B, and

10              “(ii) a per capita rate of payment for individ-  
 11 uals who are so enrolled with such an organization  
 12 and who are enrolled under part B only.

13 For purposes of this section, the term ‘risk-sharing con-  
 14 tract’ means a contract entered into under subsection (g)  
 15 and the term ‘reasonable cost reimbursement contract’  
 16 means a contract entered into under subsection (h).

17       “(B)(i) The annual per capita rate of payment for  
 18 each medicare payment area (as defined in paragraph (5))  
 19 shall be equal to 95 percent of the adjusted average per  
 20 capita cost (as defined in paragraph (4)), adjusted by the  
 21 Secretary for—

22              “(I) individuals who are enrolled under this sec-  
 23 tion with an eligible organization which has entered  
 24 into a risk-sharing contract and who are enrolled  
 25 under part B only; and

1           “(II) such risk factors as age, disability status,  
2           gender, institutional status, and such other factors  
3           as the Secretary determines to be appropriate so as  
4           to ensure actuarial equivalence.

5   The Secretary may add to, modify, or substitute for such  
6   factors, if such changes will improve the determination of  
7   actuarial equivalence.

8           “(ii) The Secretary shall reduce the annual per capita  
9   rate of payment by a uniform percentage (determined by  
10   the Secretary for a year, subject to adjustment under sub-  
11   paragraph (G)(v)) so that the total reduction is estimated  
12   to equal the amount to be paid under subparagraph (G).

13          “(C) In the case of an eligible organization with a  
14   risk-sharing contract, the Secretary shall make monthly  
15   payments in advance and in accordance with the rate de-  
16   termined under subparagraph (B) and except as provided  
17   in subsection (g)(2), to the organization for each individ-  
18   ual enrolled with the organization under this section.

19          “(D) The Secretary shall establish a separate rate of  
20   payment to an eligible organization with respect to any  
21   individual determined to have end-stage renal disease and  
22   enrolled with the organization. Such rate of payment shall  
23   be actuarially equivalent to rates paid to other enrollees  
24   in the payment area (or such other area as specified by  
25   the Secretary).



1       “(E)(i) The amount of payment under this paragraph  
2 may be retroactively adjusted to take into account any dif-  
3 ference between the actual number of individuals enrolled  
4 in the plan under this section and the number of such  
5 individuals estimated to be so enrolled in determining the  
6 amount of the advance payment.

7       “(ii)(I) Subject to subclause (II), the Secretary may  
8 make retroactive adjustments under clause (i) to take into  
9 account individuals enrolled during the period beginning  
10 on the date on that the individual enrolls with an eligible  
11 organization (that has a risk-sharing contract under this  
12 section) under a health benefit plan operated, sponsored,  
13 or contributed to by the individual’s employer or former  
14 employer (or the employer or former employer of the indi-  
15 vidual’s spouse) and ending on the date on which the indi-  
16 vidual is enrolled in the plan under this section, except  
17 that for purposes of making such retroactive adjustments  
18 under this clause, such period may not exceed 90 days.

19       “(II) No adjustment may be made under subclause  
20 (I) with respect to any individual who does not certify that  
21 the organization provided the individual with the expla-  
22 nation described in subsection (c)(3)(E) at the time the  
23 individual enrolled with the organization.

24       “(F)(i) At least 45 days before making the announce-  
25 ment under subparagraph (A) for a year, the Secretary

1 shall provide for notice to eligible organizations of pro-  
2 posed changes to be made in the methodology or benefit  
3 coverage assumptions from the methodology and assump-  
4 tions used in the previous announcement and shall provide  
5 such organizations an opportunity to comment on such  
6 proposed changes.

7       “(ii) In each announcement made under subpara-  
8 graph (A), the Secretary shall include an explanation of  
9 the assumptions (including any benefit coverage assump-  
10 tions) and changes in methodology used in the announce-  
11 ment in sufficient detail so that eligible organizations can  
12 compute per capita rates of payment for individuals lo-  
13 cated in each county (or equivalent medicare payment  
14 area) which is in whole or in part within the service area  
15 of such an organization.

16       “(2) With respect to any eligible organization that  
17 has entered into a reasonable cost reimbursement con-  
18 tract, payments shall be made to such plan in accordance  
19 with subsection (h)(2) rather than paragraph (1).

20       “(3) Subject to subsection (c) (2)(B)(ii) and (7), pay-  
21 ments under a contract to an eligible organization under  
22 paragraph (1) or (2) shall be instead of the amounts that

1 (in the absence of the contract) would be otherwise pay-  
 2 able, pursuant to sections 1814(b) and 1833(a), for serv-  
 3 ices furnished by or through the organization to individ-  
 4 uals enrolled with the organization under this section.

5 “(4)(A) For purposes of this section, the ‘adjusted  
 6 average per capita cost’ for a medicare payment area (as  
 7 defined in paragraph (5)) is equal to the greatest of the  
 8 following:

9 “(i) The sum of—

10 “(I) the area-specific percentage for the  
 11 year (as specified under subparagraph (B) for  
 12 the year) of the area-specific adjusted average  
 13 per capita cost for the year for the medicare  
 14 payment area, as determined under subpara-  
 15 graph (C), and

16 “(II) the national percentage (as specified  
 17 under subparagraph (B) for the year) of the  
 18 input-price-adjusted national adjusted average  
 19 per capita cost for the year, as determined  
 20 under subparagraph (D),

21 multiplied by a budget neutrality adjustment factor  
 22 determined under subparagraph (E).

23 “(ii) An amount equal to—

1           “(I) in the case of 1998, 80 percent of the  
2           average annual per capita cost under parts A  
3           and B of this title for 1997;

4           “(II) in the case of 1999, 80 percent of the  
5           average annual per capita cost under parts A  
6           and B of this title for 1998; and

7           “(III) in the case of a succeeding year, the  
8           amount specified in this clause for the preced-  
9           ing year increased by the national average per  
10          capita growth percentage specified under sub-  
11          paragraph (F) for that succeeding year.

12          “(iii) An amount equal to—

13               “(I) in the case of 1998, 102 percent of  
14               the annual per capita rate of payment for 1997  
15               for the medicare payment area (determined  
16               under this subsection, as in effect on the day  
17               before the date of enactment of the Medicare  
18               Modernization and Patient Protection Act of  
19               1997; and

20               “(II) in the case of a subsequent year, 102  
21               percent of the adjusted average per capita cost  
22               under this subsection for the area for the pre-  
23               vious year.

24          “(B) For purposes of subparagraph (A)(i)—

1           “(i) for 1998, the ‘area-specific percentage’ is  
2           80 percent and the ‘national percentage’ is 20 per-  
3           cent,

4           “(ii) for 1999, the ‘area-specific percentage’ is  
5           75 percent and the ‘national percentage’ is 25 per-  
6           cent,

7           “(iii) for 2000, the ‘area-specific percentage’ is  
8           70 percent and the ‘national percentage’ is 30 per-  
9           cent,

10           “(iv) for 2001, the ‘area-specific percentage’ is  
11           65 percent and the ‘national percentage’ is 35 per-  
12           cent, and

13           “(v) for 2002 and each subsequent year, the  
14           ‘area-specific percentage’ is 60 percent and the ‘na-  
15           tional percentage’ is 40 percent.

16           “(C) For purposes of subparagraph (A)(i), the area-  
17           specific adjusted average per capita cost for a medicare  
18           payment area—

19           “(i) for 1998, is the annual per capita rate of  
20           payment for 1997 for the medicare payment area  
21           (determined under this subsection, as in effect the  
22           day before the date of enactment of the Medicare  
23           Modernization and Patient Protection Act of 1997),  
24           increased by the national average per capita growth

1 percentage for 1998 (as defined in subparagraph  
2 (F)); or

3 “(ii) for a subsequent year, is the area-specific  
4 adjusted average per capita cost for the previous  
5 year determined under this subparagraph for the  
6 medicare payment area, increased by the national  
7 average per capita growth percentage for such sub-  
8 sequent year.

9 “(D)(i) For purposes of subparagraph (A)(i), the  
10 input-price-adjusted national adjusted average per capita  
11 cost for a medicare payment area for a year is equal to  
12 the sum, for all the types of medicare services (as classi-  
13 fied by the Secretary), of the product (for each such type  
14 of service) of—

15 “(I) the national standardized adjusted average  
16 per capita cost (determined under clause (ii)) for the  
17 year,

18 “(II) the proportion of such rate for the year  
19 which is attributable to such type of services, and

20 “(III) an index that reflects (for that year and  
21 that type of services) the relative input price of such  
22 services in the area compared to the national aver-  
23 age input price of such services.

24 In applying subclause (III), the Secretary shall, subject  
25 to clause (iii), apply those indices under this title that are

1 used in applying (or updating) national payment rates for  
 2 specific areas and localities.

3 “(ii) In clause (i)(I), the ‘national standardized ad-  
 4 justed average per capita cost’ for a year is equal to—

5 “(I) the sum (for all medicare payment areas)  
 6 of the product of (aa) the area-specific adjusted av-  
 7 erage per capita cost for that year for the area  
 8 under subparagraph (C), and (bb) the average num-  
 9 ber of medicare beneficiaries residing in that area in  
 10 the year; divided by

11 “(II) the total average number of medicare  
 12 beneficiaries residing in all the medicare payment  
 13 areas for that year.

14 “(iii) In applying this subparagraph for 1998—

15 “(I) medicare services shall be divided into 2  
 16 types of services: part A services and part B serv-  
 17 ices;

18 “(II) the proportions described in clause (i)(II)  
 19 for such types of services shall be—

20 “(aa) for part A services, the ratio (ex-  
 21 pressed as a percentage) of the average annual  
 22 per capita rate of payment for the area for part  
 23 A for 1997 to the total average annual per cap-  
 24 ita rate of payment for the area for parts A and  
 25 B for 1997, and

1 “(bb) for part B services, 100 percent  
 2 minus the ratio described in item (aa);

3 “(III) for part A services, 70 percent of pay-  
 4 ments attributable to such services shall be adjusted  
 5 by the index used under section 1886(d)(3)(E) to  
 6 adjust payment rates for relative hospital wage levels  
 7 for hospitals located in the payment area involved;

8 “(IV) for part B services—

9 “(aa) 66 percent of payments attributable  
 10 to such services shall be adjusted by the index  
 11 of the geographic area factors under section  
 12 1848(e) used to adjust payment rates for physi-  
 13 cians’ services furnished in the payment area,  
 14 and

15 “(bb) of the remaining 34 percent of the  
 16 amount of such payments, 70 percent shall be  
 17 adjusted by the index described in subclause  
 18 (III); and

19 “(V) the index values shall be computed based  
 20 only on the beneficiary population who are 65 years  
 21 of age or older and are not determined to have end-  
 22 stage renal disease.

23 The Secretary may continue to apply the rules described  
 24 in this clause (or similar rules) for 1999.



1       “(E) For each year, the Secretary shall compute a  
2 budget neutrality adjustment factor so that the aggregate  
3 of the payments under this section shall not exceed the  
4 aggregate payments that would have been made under this  
5 section if the area-specific percentage for the year had  
6 been 100 percent and the national percentage had been  
7 0 percent.

8       “(F) In this section, the ‘national average per capita  
9 growth percentage’ for a year is equal to the Secretary’s  
10 estimate (after consultation with the Secretary of the  
11 Treasury) of the 3-year average (ending with the year in-  
12 volved) of the annual rate of growth in the national aver-  
13 age wage index (as defined in section 209(k)(1)) for each  
14 year in the period.

15       “(5)(A) In this section the term ‘medicare payment  
16 area’ means a county, or equivalent area specified by the  
17 Secretary.

18       “(B) In the case of individuals who are determined  
19 to have end-stage renal disease, the medicare payment  
20 area shall be each State.

21       “(6) The payment to an eligible organization under  
22 this section for individuals enrolled under this section with  
23 the organization and entitled to benefits under part A and  
24 enrolled under part B shall be made from the Federal

1 Hospital Insurance Trust Fund and the Federal Supple-  
2 mentary Medical Insurance Trust Fund. The portion of  
3 that payment to the organization for a month to be paid  
4 by each trust fund shall be determined as follows:

5           “(A) In regard to expenditures by eligible orga-  
6           nizations having risk-sharing contracts, the alloca-  
7           tion shall be determined each year by the Secretary  
8           based on the relative weight that benefits from each  
9           fund contribute to the adjusted average per capita  
10          cost.

11           “(B) In regard to expenditures by eligible orga-  
12          nizations operating under a reasonable cost reim-  
13          bursement contract, the initial allocation shall be  
14          based on the plan’s most recent budget, such alloca-  
15          tion to be adjusted, as needed, after cost settlement  
16          to reflect the distribution of actual expenditures.

17 The remainder of that payment shall be paid by the  
18 former trust fund.

19           “(7) Subject to paragraphs (2)(B)(ii) and (7) of sub-  
20 section (c), if an individual is enrolled under this section  
21 with an eligible organization having a risk-sharing con-  
22 tract, only the eligible organization shall be entitled to re-  
23 ceive payments from the Secretary under this title for  
24 services furnished to the individual.”.

1           (2) EFFECTIVE DATE.—The amendment made  
2       by this subsection shall take effect on October 1,  
3       1997.

4       (b) QUALITY STANDARDS.—

5           (1) REVISION OF CURRENT REQUIREMENTS;  
6       DEEMED STATUS OF ACCREDITED ORGANIZA-  
7       TIONS.—Section 1876(c)(6) of the Social Security  
8       Act (42 U.S.C. 1395mm(c)(6)) is amended to read  
9       as follows:

10       “(6)(A) The organization must meet quality stand-  
11       ards established by the Secretary in consultation with ap-  
12       propriate private quality accreditation entities. Such  
13       standards shall include a requirement that the organiza-  
14       tion have arrangements for an ongoing quality assurance  
15       program for health care services it provides to such indi-  
16       viduals, which (i) stresses health outcomes, and (ii) pro-  
17       vides review by physicians and other health care profes-  
18       sionals of the process followed in the provision of such  
19       health care services.

20       “(B) If the Secretary finds that accreditation of an  
21       organization by the National Committee on Quality Assur-  
22       ance or any other national accreditation body provides rea-  
23       sonable assurance that the organization meets quality  
24       standards at least as stringent as those established under  
25       subparagraph (A), then any organization so accredited is

1 deemed to have met the quality standards established  
2 under such subparagraph.”.

3 (2) WAIVER OF “50/50” RULE FOR CERTAIN OR-  
4 GANIZATIONS.—Section 1876(f) of the Social Secu-  
5 rity Act (42 U.S.C. 1395mm(f)) is amended by add-  
6 ing at the end the following:

7 “(4) The requirement of paragraph (1) shall not  
8 apply in the case of an organization that either—

9 “(A) is (and has been for a minimum period  
10 specified by the Secretary and not longer than 3  
11 years) accredited by an accreditation body described  
12 in subsection (c)(6)(B), or

13 “(B) the Secretary determines has met (or has  
14 been deemed to have met) the quality standards de-  
15 scribed in subsection (c)(6)(A) over a minimum pe-  
16 riod specified by the Secretary.”.

17 (c) ENROLLMENT AND DISENROLLMENT PERIODS.—

18 (1) MONTHLY ENROLLMENT PERIOD.—Section  
19 1876(c)(3) of the Social Security Act (42 U.S.C.  
20 1395mm(c)(3)) is amended by striking subpara-  
21 graph (A) and inserting the following:

22 “(A) Each eligible organization shall have a monthly  
23 enrollment period for the enrollment of individuals under  
24 this section, and shall provide that at any time during

1 which enrollments are accepted, the organization will ac-  
 2 cept up to the limits of its capacity (as determined by the  
 3 Secretary) and without restrictions, except as may be au-  
 4 thorized in regulations, individuals who are eligible to en-  
 5 roll under subsection (d) in the order in which they apply  
 6 for enrollment, unless to do so would result in failure to  
 7 meet the requirements of subsection (f) or would result  
 8 in the enrollment of enrollees substantially nonrepresenta-  
 9 tive, as determined in accordance with regulations of the  
 10 Secretary, of the population in the geographic area served  
 11 by the organization.”.

12 (2) DISENROLLMENT PERIOD.—The first sen-  
 13 tence of section 1876(c)(3)(B) of the Social Security  
 14 Act (42 U.S.C. 1395mm(c)(3)(B)) is amended to  
 15 read as follows:

16 “(B) An individual may enroll under this section with  
 17 an eligible organization in such manner as may be pre-  
 18 scribed in regulations and may terminate that enrollment  
 19 with that eligible organization as of the first day of every  
 20 month if the request for termination is made during the  
 21 first year that the individual is enrolled with that organi-  
 22 zation and as of the first day of every sixth month follow-  
 23 ing such request thereafter.”.

24 (d) REQUIREMENTS FOR SERVICE AREAS.—

1           (1) IN GENERAL.—Section 1876 of the Social  
2       Security Act (42 U.S.C. 1395mm) is amended by  
3       adding at the end the following:

4       “(k)(1) Except as provided in paragraph (2), for pur-  
5       poses of this section, if an eligible organization’s service  
6       area includes any part of a metropolitan statistical area,  
7       the service area shall include the entire metropolitan sta-  
8       tistical area (including any area designated by the Sec-  
9       retary as a health professional shortage area under section  
10      332(a)(1)(A) of the Public Health Service Act within such  
11      metropolitan statistical area).

12      “(2) The Secretary may permit an organization’s  
13      service area to exclude any portion of a metropolitan sta-  
14      tistical area (other than the central county of such metro-  
15      politan statistical area) if—

16           “(A) the organization demonstrates that it  
17      lacks the financial or administrative capacity to  
18      serve the entire metropolitan statistical area; and

19           “(B) the Secretary finds that the composition  
20      of the organization’s service area does not reduce  
21      the financial risk to the organization of providing  
22      services to enrollees because of the health status or  
23      other demographic characteristics of individuals re-  
24      siding in the service area (as compared to the health  
25      status or demographic characteristics of individuals

1       residing in the portion of the metropolitan statistical  
 2       area not included in the organization’s service  
 3       area).”.

4               (2)       CONFORMING       AMENDMENT.—Section  
 5       1876(c)(4)(A)(i) of the Social Security Act (42  
 6       U.S.C. 1395mm(c)(4)(A)(i)) is amended by striking  
 7       “the area served by the organization” and inserting  
 8       “the organization’s service area”.

9       (e) OTHER ENROLLEE PROTECTIONS.—

10              (1)       CLARIFICATION OF RESTRICTIONS ON  
 11       CHARGES FOR OUT-OF-PLAN SERVICES.—

12                      (A) INPATIENT HOSPITAL AND EXTENDED  
 13       CARE SERVICES.—Section 1866(a)(1)(O) of the  
 14       Social Security Act (42 U.S.C.  
 15       1395cc(a)(1)(O)) is amended in the matter pre-  
 16       ceding clause (i) by inserting after “this title”  
 17       the following: “(without regard to whether or  
 18       not the services are furnished on an emergency  
 19       basis)”.

20                      (B) PHYSICIANS’ SERVICES AND RENAL DI-  
 21       ALYSIS SERVICES.—Section 1876(j)(1)(A) of  
 22       the Social Security Act (42 U.S.C.  
 23       1395mm(j)(1)(A)) is amended by striking “this

1           section” and inserting “this section (without re-  
 2           gard to whether or not the services are fur-  
 3           nished on an emergency basis)”.

4           (2) ARRANGEMENTS FOR DIALYSIS SERVICES.—

5           Section 1876(c) of the Social Security Act (42  
 6           U.S.C. 1395mm(c)) is amended by adding at the  
 7           end the following:

8           “(9) Each eligible organization shall assure that en-  
 9           rollees requiring renal dialysis services who are tempo-  
 10          rarily outside of the organization’s service area (within the  
 11          United States) have reasonable access to such services  
 12          by—

13           “(A) making such arrangements with providers  
 14          of services or renal dialysis facilities outside the  
 15          service area for the coverage of and payment for  
 16          such services furnished to enrollees as the Secretary  
 17          determines necessary to assure reasonable access; or

18           “(B) providing for the reimbursement of any  
 19          provider of services or renal dialysis facility outside  
 20          the service area for the furnishing of such services  
 21          to enrollees.”.

22           (3) STUDY AND REPORT.—

23           (A) STUDY.—The Secretary shall conduct  
 24          a study of how to provide increased portability



1 of items and services provided under a plan of-  
2 fered by an eligible organization with a risk-  
3 sharing contract under section 1876 of the So-  
4 cial Security Act (42 U.S.C. 1395mm).

5 (B) REPORT TO CONGRESS.—Not later  
6 than 18 months after the date of enactment of  
7 this Act, the Secretary shall submit a report to  
8 Congress which shall contain a detailed state-  
9 ment of the findings and conclusions of the Sec-  
10 retary with respect to the study conducted  
11 under subparagraph (A), together with the Sec-  
12 retary’s recommendations for such legislation  
13 and administrative actions as the Secretary con-  
14 siders appropriate.

15 (f) OUTLIER PAYMENTS.— Section 1876(a)(1) of the  
16 Social Security Act (42 U.S.C. 1395mm(a)(1)) (as amend-  
17 ed by subsection (a) of this section) is amended by adding  
18 at the end the following:

19 “(G)(i) In the case of an eligible organization with  
20 a risk-sharing contract, the Secretary may make addi-  
21 tional payments to the organization equal to not more  
22 than 50 percent of the imputed reasonable cost (or, if so  
23 requested by the organization, the reasonable cost) above  
24 the threshold amount of services covered under parts A

1 and B and provided (or paid for) in a year by the organi-  
2 zation to any individual enrolled with the organization  
3 under this section.

4 “(ii) For purposes of clause (i), the ‘imputed reason-  
5 able cost’ is an amount determined by the Secretary on  
6 a national, regional, or other basis that is related to the  
7 reasonable cost of services.

8 “(iii) For purposes of clause (i), the ‘threshold  
9 amount’ is an amount determined by the Secretary from  
10 time to time, adjusted by the geographic factor utilized  
11 in determining payments to the organization under sub-  
12 paragraph (B) and rounded to the nearest multiple of  
13 \$100, such that the total amount to be paid under this  
14 subparagraph for a year is estimated to be 5 percent or  
15 less of the total amount to be paid under risk-sharing con-  
16 tracts for services furnished for that year.

17 “(iv) An eligible organization shall submit a claim for  
18 additional payments under subsection (i) within such time  
19 as the Secretary may specify.

20 “(v) To the extent that total payments under clause  
21 (i) in a year—

22 “(I) exceed the payment set aside as a result of  
23 the reduction under subparagraph (B) for the year,  
24 the Secretary shall increase the percentage reduction  
25 under such subparagraph for the following year by

1 such percentage as will result in an increase in the  
 2 reduction equal to such excess in previous payments,  
 3 or

4 “(II) are less than the payment set aside as a  
 5 result of the reduction under subparagraph (B) for  
 6 the year, the amount of such difference shall remain  
 7 available in the succeeding years for additional pay-  
 8 ments under this subparagraph and the Secretary  
 9 may take such difference into account in establishing  
 10 the percentage reduction under subparagraph (B)  
 11 for the following year.”.

12 (g) APPLICATION OF INTERMEDIATE SANCTIONS FOR  
 13 ANY PROGRAM VIOLATIONS.—

14 (1) IN GENERAL.—Section 1876(i)(1) of the  
 15 Social Security Act (42 U.S.C. 1395mm(i)(1)) is  
 16 amended by striking “the Secretary may terminate”  
 17 and all that follows and inserting the following: “in  
 18 accordance with procedures established under para-  
 19 graph (9), the Secretary may at any time terminate  
 20 any such contract or impose the intermediate sanc-  
 21 tions described in subparagraph (B) or (C) of para-  
 22 graph (6) (whichever is applicable) on the eligible or-  
 23 ganization if the Secretary determines that the orga-  
 24 nization—

1           “(A) has failed substantially to carry out the  
2       contract;

3           “(B) is carrying out the contract in a manner  
4       inconsistent with the efficient and effective adminis-  
5       tration of this section;

6           “(C) is operating in a manner that is not in the  
7       best interests of the individuals covered under the  
8       contract; or

9           “(D) no longer substantially meets the applica-  
10      ble conditions of subsections (b), (c), (e), and (f).”.

11           (2) OTHER INTERMEDIATE SANCTIONS FOR  
12      MISCELLANEOUS PROGRAM VIOLATIONS.—Section  
13      1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by  
14      adding at the end the following:

15      “(C) In the case of an eligible organization for which  
16      the Secretary makes a determination under paragraph (1)  
17      the basis of which is not described in subparagraph (A),  
18      the Secretary may apply the following intermediate sanc-  
19      tions:

20           “(i) Civil money penalties of not more than  
21      \$25,000 for each determination under paragraph (1)  
22      if the deficiency that is the basis of the determina-  
23      tion has directly adversely affected (or has the sub-  
24      stantial likelihood of adversely affecting) an individ-  
25      ual covered under the organization’s contract.

1           “(ii) Civil money penalties of not more than  
 2           \$10,000 for each week beginning after the initiation  
 3           of procedures by the Secretary under paragraph (9)  
 4           during which the deficiency that is the basis of a de-  
 5           termination under paragraph (1) exists.

6           “(iii) Suspension of enrollment of individuals  
 7           under this section after the date the Secretary noti-  
 8           fies the organization of a determination under para-  
 9           graph (1) and until the Secretary is satisfied that  
 10          the deficiency that is the basis for the determination  
 11          has been corrected and is not likely to recur.”.

12           (3) PROCEDURES FOR IMPOSING SANCTIONS.—  
 13          Section 1876(i) (42 U.S.C. 1395mm(i)) is amended  
 14          by adding at the end the following:

15          “(9) The Secretary may terminate a contract with an  
 16          eligible organization under this section or may impose the  
 17          intermediate sanctions described in paragraph (6) on the  
 18          organization in accordance with formal investigation and  
 19          compliance procedures established by the Secretary under  
 20          which—

21                 “(A) the Secretary provides the organization  
 22                 with the opportunity to develop and implement a  
 23                 corrective action plan to correct the deficiencies that  
 24                 were the basis of the Secretary’s determination  
 25                 under paragraph (1);

1           “(B) the Secretary imposes more severe sanc-  
 2           tions on organizations that have a history of defi-  
 3           ciencies or that have not taken steps to correct defi-  
 4           ciencies the Secretary has brought to their attention;

5           “(C) there are no unreasonable or unnecessary  
 6           delays between the finding of a deficiency and the  
 7           imposition of sanctions; and

8           “(D) the Secretary provides the organization  
 9           with reasonable notice and opportunity for hearing  
 10          (including the right to appeal an initial decision) be-  
 11          fore imposing any sanction or terminating the con-  
 12          tract.”.

13           (4) CONFORMING AMENDMENTS.—

14                   (A) Section 1876(i)(6)(B) of the Social Se-  
 15                   curity Act (42 U.S.C. 1395mm(i)(6)(B)) is  
 16                   amended by striking the second sentence.

17                   (B) Section 1876(i)(6) of the Social Secu-  
 18                   rity Act (42 U.S.C. 1395mm(i)(6)) is further  
 19                   amended by adding at the end the following:

20           “(D) The provisions of section 1128A (other than  
 21           subsections (a), (b), and (m)) shall apply to a civil money  
 22           penalty under subparagraph (A) or (B) in the same man-  
 23           ner as they apply to a civil money penalty or proceeding  
 24           under section 1128A(a).”.

1 (h) AGREEMENTS WITH PEER REVIEW ORGANIZA-  
2 TIONS.—

3 (1) REQUIREMENT FOR WRITTEN AGREE-  
4 MENT.—Section 1876(i)(7)(A) of the Social Security  
5 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by  
6 striking “an agreement” and inserting “a written  
7 agreement”.

8 (2) DEVELOPMENT OF MODEL AGREEMENT.—  
9 Not later than July 1, 1998, the Secretary shall de-  
10 velop a model of the agreement that an eligible orga-  
11 nization with a risk-sharing contract under section  
12 1876 of the Social Security Act (42 U.S.C.  
13 1395mm) must enter into with an entity providing  
14 peer review services with respect to services provided  
15 by the organization under section 1876(i)(7)(A) of  
16 that Act.

17 (3) REPORT BY GAO.—

18 (A) STUDY.—The Comptroller General of  
19 the United States shall conduct a study of the  
20 costs incurred by eligible organizations with  
21 risk-sharing contracts under section 1876 of the  
22 Social Security Act (42 U.S.C. 1395mm) of  
23 complying with the requirement of entering into  
24 a written agreement with an entity providing

1 peer review services with respect to services pro-  
 2 vided by the organization, together with an  
 3 analysis of how information generated by such  
 4 entities is used by the Secretary to assess the  
 5 quality of services provided by such eligible or-  
 6 ganizations.

7 (B) REPORT TO CONGRESS.—Not later  
 8 than July 1, 1998, the Comptroller General of  
 9 the United States shall submit a report to the  
 10 Committee on Ways and Means and the Com-  
 11 mittee on Commerce of the House of Represent-  
 12 atives and the Committee on Finance of the  
 13 Senate on the study conducted under subpara-  
 14 graph (A).

15 (i) ELIMINATION OF GAG CLAUSES.—

16 (1) IN GENERAL.—Section 1876(i) of the So-  
 17 cial Security Act (42 U.S.C. 1395mm(i)) (as amend-  
 18 ed by subsection (g)) is amended by adding at the  
 19 end the following:

20 “(10)(A) Each contract with an eligible organization  
 21 under this section shall provide that the organization may  
 22 not prohibit an applicable individual from openly commu-  
 23 nicating, within the scope of such individual’s license (or  
 24 such individual’s group license), with any patient of such



1 individual who is covered under this section with respect  
 2 to such patients’—

3 “(i) physical or mental condition;

4 “(ii) medical care; or

5 “(iii) appropriate treatment options.

6 “(B) As used in this paragraph, the term ‘applicable  
 7 individual’ means a health care provider who—

8 “(i) provides items and services under this sec-  
 9 tion; and

10 “(ii) is licensed or certified by the State in  
 11 which such items and services are provided.”.

12 (2) ENFORCEMENT.—Section 1876(i)(6)(A)(vi)  
 13 of the Social Security Act (42 U.S.C.  
 14 1395mm(i)(6)(A)(iv)) is amended by striking “para-  
 15 graph (8)” and inserting “paragraph (8) or (10)”.

16 (j) EFFECTIVE DATE.—Except as otherwise pro-  
 17 vided, the amendments made by this section shall apply  
 18 to contract years beginning with 1998.

19 **SEC. 202. QUALITY REPORT CARDS AND COMPARATIVE RE-**  
 20 **PORTS.**

21 Title XVIII of the Social Security Act (42 U.S.C.  
 22 1395 et seq.) is amended by inserting after section 1804  
 23 the following:

24 “QUALITY REPORT CARDS AND COMPARATIVE REPORTS

25 “SEC. 1805. (a) DISTRIBUTION OF QUALITY REPORT  
 26 CARDS AND COMPARATIVE REPORTS.—Beginning with

1 calendar year 1998, the Secretary shall include with the  
 2 notice distributed under section 1804 a quality report card  
 3 and a comparative report. The quality report card and  
 4 comparative report shall contain information designed to  
 5 assist medicare beneficiaries in choosing eligible organiza-  
 6 tions including a comparison of benefits, costs, and the  
 7 quality indicators developed under subsection (b).

8 “(b) QUALITY REPORT CARDS.—

9 “(1) IN GENERAL.—The Secretary shall develop  
 10 quality indicators for eligible organizations that will  
 11 assist medicare beneficiaries’ decisionmaking regard-  
 12 ing health care and treatment by allowing the bene-  
 13 ficiaries to compare quality information.

14 “(2) QUALITY INDICATORS DESCRIBED.—The  
 15 quality indicators developed under paragraph (1)  
 16 may include the following:

17 “(A) Information on the number of mem-  
 18 bers of an eligible organization who disenroll  
 19 from the organization.

20 “(B) Outcomes of care.

21 “(C) Population health status.

22 “(D) Appropriateness of care.

23 “(E) Consumer satisfaction for general  
 24 and subgroup populations.

1           “(F) Access to care, including access to  
2           emergency care, waiting time for scheduled ap-  
3           pointments, and provider location convenience.

4           “(G) Prevention of diseases, disorders, dis-  
5           abilities, injuries, and other health conditions.

6           “(3) ONGOING BASIS.—Development of quality  
7           indicators shall be done on an ongoing basis.

8           “(c) COMPARATIVE REPORTS.—

9           “(1) IN GENERAL.—The Secretary shall develop  
10          an understandable standardized comparative report  
11          on the plans offered by eligible organizations, that  
12          will assist medicare beneficiaries’ decisionmaking re-  
13          garding health care and treatment by allowing the  
14          beneficiaries to compare the organizations that the  
15          beneficiaries are eligible to enroll with.

16          “(2) CONTENTS OF REPORT.—The report de-  
17          scribed in paragraph (1) shall include a comparison  
18          of the following:

19               “(A) The monthly premium.

20               “(B) The amount of any deductibles and  
21          coinsurance.

22               “(C) The choice of doctors.

23               “(D) The choice of hospitals.

24               “(E) The service area.

25               “(F) Emergency room care coverage.

1 “(G) Hospital charges.

2 “(H) Physician charges.

3 “(I) Coverage of prescription drugs.

4 “(J) Ambulance coverage.

5 “(K) Coverage of routine eye exams and  
6 eyeglasses.

7 “(L) Coverage of skilled nursing facilities  
8 and home health care.

9 “(M) Coverage of hearing exams and hear-  
10 ing aids.

11 “(N) Coverage of mental health therapy.

12 “(O) Any physician financial incentives.

13 “(P) The number of members in the plan.

14 “(Q) The number of individuals who volun-  
15 tarily enrolled and disenrolled in the plan dur-  
16 ing the previous fiscal year.

17 “(R) The percentage of physicians in the  
18 plan who left the plan during the previous fiscal  
19 year.

20 “(S) Whether the plan offers a point of  
21 service option.

22 “(T) The number of applications during  
23 the previous fiscal year requesting that the plan  
24 cover certain out-of-network services and the  
25 number of such applications that were denied.

1           “(U) Any other materials that the Sec-  
 2           retary determines would be helpful for bene-  
 3           ficiaries to compare the organizations that the  
 4           beneficiaries are eligible to enroll with.

5           “(d) FUNDING AND COMPLIANCE.—

6           “(1) IN GENERAL.—Each eligible organization  
 7           shall—

8           “(A) disclose quality indicator data and  
 9           the information necessary to complete the com-  
 10          parative report as requested, to the Secretary;  
 11          and

12          “(B) pay to the Secretary the pro rata  
 13          share, as determined by the Secretary, of the  
 14          estimated costs to be incurred by the Secretary  
 15          in carrying out the requirements of this section.

16          “(2) APPROPRIATION.—Any funds received in  
 17          the Treasury as a result of payments made under  
 18          paragraph (1)(B) are authorized to be appropriated  
 19          and are appropriated to the Secretary, for the pur-  
 20          poses described in such paragraph, and shall remain  
 21          available until expended.

22          “(e) DEFINITIONS.—In this section—

23          “(1) the term ‘eligible organization’ means an  
 24          organization with a risk-sharing contract under sec-  
 25          tion 1876;

1           “(2) the term ‘medicare beneficiary’ means an  
2           individual entitled to benefits under part A or en-  
3           rolled under part B; and

4           “(3) the term ‘provider’ means hospitals, physi-  
5           cians, nursing homes, and providers of ancillary  
6           services to medicare beneficiaries.”.

7   **SEC. 203. PREEMPTION OF STATE LAWS RESTRICTING MAN-**  
8           **AGED CARE.**

9           (a) PREEMPTION OF STATE BENEFIT MANDATES.—  
10   No State shall establish or enforce any law or regulation  
11   that requires the offering, as part of health insurance cov-  
12   erage to be offered to an individual entitled to benefits  
13   under the medicare program, of any services, category of  
14   care, or services of any class or type of provider.

15          (b) PREEMPTION OF STATE LAW RESTRICTIONS ON  
16   MANAGED CARE ARRANGEMENTS.—

17           (1) LIMITATION ON RESTRICTIONS ON NET-  
18   WORK PLANS.—A State may not prohibit or limit—

19           (A) a carrier or group health plan provid-  
20           ing health coverage from including incentives  
21           for enrollees to use the services of participating  
22           providers;

23           (B) such a carrier or plan from limiting  
24           coverage of services to those provided by a par-  
25           ticipating provider;

1 (C) the negotiation of rates and forms of  
 2 payments for providers by such a carrier or  
 3 plan with respect to health coverage;

4 (D) such a carrier or plan from limiting  
 5 the number of participating providers;

6 (E) such a carrier or plan from requiring  
 7 that services be provided (or authorized) by a  
 8 practitioner selected by the enrollee from a list  
 9 of available participating providers or from re-  
 10 quiring enrollees to obtain referral in order to  
 11 have coverage for treatment by a specialist or  
 12 health institution; and

13 (F) the corporate practice of medicine.

14 (2) DEFINITIONS.—In this subsection:

15 (A) MANAGED CARE ARRANGEMENT.—The  
 16 term “managed care arrangement” means, with  
 17 respect to an arrangement under a group health  
 18 plan or under health insurance coverage, pro-  
 19 viders who have entered into an agreement  
 20 under the arrangement under which such pro-  
 21 viders are obligated to provide items and serv-  
 22 ices covered under the arrangement to individ-  
 23 uals covered under the plan or who have such  
 24 coverage.

1 (B) MANAGED CARE COVERAGE.—The  
 2 term “managed care coverage” means health  
 3 coverage to the extent the coverage is provided  
 4 through a managed care arrangement (as de-  
 5 fined in subparagraph (A)).

6 (C) PARTICIPATING PROVIDER.—The term  
 7 “participating provider” means an entity or in-  
 8 dividual that provides, sells, or leases health  
 9 care services as part of a provider network (as  
 10 defined in subparagraph (D)).

11 (D) PROVIDER NETWORK.—The term  
 12 “provider network” means, with respect to a  
 13 group health plan or health insurance coverage,  
 14 providers who have entered into an agreement  
 15 described in subparagraph (A) under a man-  
 16 aged care arrangement.

17 (c) PREEMPTION OF STATE LAWS RESTRICTING UTI-  
 18 LIZATION REVIEW PROGRAMS.—

19 (1) IN GENERAL.—No State law or regulation  
 20 shall prohibit or regulate activities under a utiliza-  
 21 tion review program (as defined in paragraph (2)).

22 (2) UTILIZATION REVIEW PROGRAM DE-  
 23 FINED.—In this subsection, the term “utilization re-  
 24 view program” means a system of reviewing the  
 25 medical necessity and appropriateness of patient



1 services (which may include inpatient and outpatient  
 2 services) using specified guidelines. Such a system  
 3 may include preadmission certification, the applica-  
 4 tion of practice guidelines, continued stay review,  
 5 discharge planning, preauthorization of ambulatory  
 6 procedures, and retrospective review.

7 (3) EXEMPTION OF LAWS PREVENTING DENIAL  
 8 OF LIFESAVING MEDICAL TREATMENT PENDING  
 9 TRANSFER TO ANOTHER HEALTH CARE PROVIDER.—  
 10 Nothing in this section shall be construed to invali-  
 11 date any State law that has the effect of preventing  
 12 involuntary denial of life-preserving medical treat-  
 13 ment when such denial would cause the involuntary  
 14 death of the patient pending transfer of the patient  
 15 to a health care provider willing to provide such  
 16 treatment.

17 (d) EFFECTIVE DATE.—This section takes effect on  
 18 January 1, 1998.

19 **SEC. 204. APPEALS.**

20 (a) OMBUDSMAN FOR MEDICARE HMO'S.—Section  
 21 1876(c) of the Social Security Act (42 U.S.C. 1395mm(c))  
 22 (as amended by section 201(e)(2) of this Act) is amended  
 23 by adding at the end the following:

1       “(10) The organization shall designate an independ-  
 2   ent ombudsman to assist members enrolled with such or-  
 3   ganization with exercising such members’ right to file  
 4   grievances and appeals under paragraph (5).”.

5       (b) NOTICE BY MEDICARE HMO’S OF RIGHT TO  
 6   FILE GRIEVANCES AND APPEALS.—Section 1876(c)(5) of  
 7   the Social Security Act (42 U.S.C. 1395mm(c)(5)) is  
 8   amended by adding at the end the following:

9       “(C)(i) The organization shall provide to a member  
 10   enrolled with the organization a clear and understandable  
 11   statement regarding such member’s right to file grievances  
 12   and appeals under paragraph (5).

13       “(ii) The statement described in clause (i) shall be  
 14   provided to the member each time the member applies to  
 15   the organization for items or services to be covered.”.

16       (c) EXPEDITING DETERMINATIONS AND APPEALS.—

17       (1) IN GENERAL.—Not later than 90 days after  
 18   the date of enactment of this Act, the Secretary  
 19   shall promulgate regulations that are intended to ex-  
 20   pedite determinations and appeals regarding covered  
 21   items and services for individuals who are entitled to  
 22   items and services under part A and eligible for  
 23   items and services under part B of title XVIII of the  
 24   Social Security Act.

1           (2) CONTENTS.—In promulgating the regula-  
 2           tions required under paragraph (1), the Secretary  
 3           shall consider whether to include a regulation that  
 4           states that an individual need not partake in a fair  
 5           hearing regarding a covered service if Health Care  
 6           Financing Administration policy would require the  
 7           fair hearing officer to rule against the individual.

8   **SEC. 205. MEDICARE HMO ENROLLMENT FAIR.**

9           (a) IN GENERAL.—Section 1876 of the Social Secu-  
 10          rity Act (42 U.S.C. 1395mm) (as amended by section  
 11          201(d) of this Act) is amended by adding at the end the  
 12          following:

13          “(l) In the month of November of each year, the Sec-  
 14          retary shall coordinate an annual enrollment fair in each  
 15          medicare payment area in order for eligible organizations  
 16          to inform individuals eligible to enroll in the plans offered  
 17          by those organizations under this section about the aspects  
 18          of those plans, including the aspects described in section  
 19          1805(c)(2).”.

20          (b) REQUIREMENT FOR ELIGIBLE ORGANIZA-  
 21          TIONS.—Section 1876(c) of the Social Security Act (42  
 22          U.S.C. 1395mm(c)) (as amended by section 204(a) of this  
 23          Act) is amended by adding at the end the following:

24          “(11) The organization shall participate in the an-  
 25          nual enrollment fair (coordinated by the Secretary under

1 subsection (l)) in each medicare payment area in which  
 2 the organization offers a plan under this section.”.

### 3 **Subtitle B—Maintaining Fee-for-** 4 **Service Program**

#### 5 **SEC. 211. FAILSAFE BUDGET MECHANISM.**

6 (a) IN GENERAL.—Title XVIII of the Social Security  
 7 Act (42 U.S.C. 1395 et seq.) is amended by adding at  
 8 the end the following:

9 “FAILSAFE BUDGET MECHANISM

10 “SEC. 1894. (a) REQUIREMENT OF PAYMENT AD-  
 11 JUSTMENTS TO ACHIEVE MEDICARE BUDGET TAR-  
 12 GETS.—

13 “(1) IN GENERAL.—If the Secretary determines  
 14 under subsection (e)(3)(C) before a fiscal year (be-  
 15 ginning with fiscal year 2000) that—

16 “(A) the fee-for-service expenditures (as  
 17 defined in subsection (f)) for all sectors of med-  
 18 icare services (as defined in subsection (b)) for  
 19 the fiscal year, will exceed

20 “(B) the sum of the allotments specified  
 21 under subsection (c)(2) for such fiscal year  
 22 (taking into account any adjustment in the al-  
 23 lotment under subsection (g) for that fiscal  
 24 year) for all sectors,

25 then, notwithstanding any other provision of this  
 26 title, there shall be an adjustment (consistent with

1 subsection (d)) in applicable payment rates or pay-  
 2 ments for items and services included in each excess  
 3 spending sector in the fiscal year. In this section,  
 4 the term ‘aggregate excess spending’ means, for a  
 5 fiscal year, the amount by which the amount de-  
 6 scribed in subparagraph (A) (for the fiscal year) ex-  
 7 ceeds the amount described in subparagraph (B) for  
 8 such year.

9 “(2) EXCESS SPENDING SECTOR.—In this sec-  
 10 tion, the term ‘excess spending sector’ means, for a  
 11 fiscal year, a sector of medicare services for which  
 12 the Secretary determines under subsection  
 13 (e)(3)(C)—

14 “(A) the fee-for-service expenditures (as  
 15 defined in subsection (f)) for the fiscal year,  
 16 will exceed

17 “(B) the allotment specified under sub-  
 18 section (c)(2) for such fiscal year (taking into  
 19 account any adjustment in the allotment under  
 20 subsection (g) for that fiscal year).

21 In this section, the term ‘excess spending’ means,  
 22 for a fiscal year with respect to such a sector, the  
 23 amount by which the amount described in subpara-  
 24 graph (A) (for the fiscal year and sector) exceeds

1 the amount described in subparagraph (B) for such  
 2 year and sector.

3 “(b) SECTORS OF MEDICARE SERVICES DE-  
 4 SCRIBED.—

5 “(1) IN GENERAL.—For purposes of this sec-  
 6 tion, items and services included under each of the  
 7 following subparagraphs shall be considered to be a  
 8 separate ‘sector’ of medicare services:

9 “(A) Inpatient hospital services.

10 “(B) Home health services.

11 “(C) Extended care services (for inpatients  
 12 of skilled nursing facilities).

13 “(D) Hospice care.

14 “(E) Physicians’ services (including serv-  
 15 ices and supplies described in section  
 16 1861(s)(2)(A)) and services of other health care  
 17 professionals (including certified registered  
 18 nurse anesthetists, nurse practitioners, physi-  
 19 cian assistants, and clinical psychologists) for  
 20 which separate payment is made under this  
 21 title.

22 “(F) Outpatient hospital services and am-  
 23 bulatory facility services.

24 “(G) Durable medical equipment and sup-  
 25 plies, including prosthetic devices and orthotics.

1                   “(H) Diagnostic tests (including clinical  
2                   laboratory services and x-ray services).

3                   “(I) Other items and services.

4                   “(2) CLASSIFICATION OF ITEMS AND SERV-  
5                   ICES.—The Secretary shall classify each type of item  
6                   and service covered and paid for separately under  
7                   this title into one of the sectors specified in para-  
8                   graph (1). After publication of such classification  
9                   under subsection (e)(1), the Secretary is not author-  
10                  ized to make substantive changes in such classifica-  
11                  tion.

12                  “(c) ALLOTMENT.—

13                  “(1) ALLOTMENTS FOR EACH SECTOR.—For  
14                  purposes of this section, subject to subsection (g)(1),  
15                  the allotment for a sector of medicare services for a  
16                  fiscal year is equal to the product of—

17                         “(A) the total allotment for the fiscal year  
18                         established under paragraph (2), and

19                         “(B) the allotment proportion (specified  
20                         under paragraph (3)) for the sector and fiscal  
21                         year involved.

22                  “(2) TOTAL ALLOTMENT.—

23                         “(A) IN GENERAL.—For purposes of this  
24                         section, the total allotment for a fiscal year is  
25                         equal to—

1 “(i) the medicare benefit budget for  
 2 the fiscal year (as specified under subpara-  
 3 graph (B)), reduced by

4 “(ii) the amount of payments the Sec-  
 5 retary estimates will be made in the fiscal  
 6 year under section 1876.

7 In making the estimate under clause (ii), the  
 8 Secretary shall take into account estimated en-  
 9 rollment and demographic profile of individuals  
 10 electing to enroll in section 1876.

11 “(B) MEDICARE BENEFIT BUDGET.—For  
 12 purposes of this subsection, subject to subpara-  
 13 graph (C), the ‘medicare benefit budget’—

14 “(i) for fiscal year 1998 is  
 15 \$225,070,000,000;

16 “(ii) for fiscal year 1999 is  
 17 \$239,590,000,000;

18 “(iii) for fiscal year 2000 is  
 19 \$252,490,000,000;

20 “(iv) for fiscal year 2001 is  
 21 \$271,890,000,000;

22 “(v) for fiscal year 2002 is  
 23 \$292,020,000,000; and

24 “(viii) for a subsequent fiscal year is  
 25 equal to the medicare benefit budget under



1           this subparagraph for the preceding fiscal  
 2           year multiplied by the product of (I) 1.05,  
 3           and (II) 1 plus the annual percentage in-  
 4           crease in the average number of medicare  
 5           beneficiaries from the previous fiscal year  
 6           to the fiscal year involved.

7           “(3) MEDICARE ALLOTMENT PROPORTION DE-  
 8       FINED.—

9           “(A) IN GENERAL.—For purposes of this  
 10          section and with respect to a sector of medicare  
 11          services for a fiscal year, the term ‘medicare al-  
 12          lotment proportion’ means the ratio of—

13               “(i) the baseline-projected medicare  
 14               expenditures (as determined under sub-  
 15               paragraph (B)) for the sector for the fiscal  
 16               year, to

17               “(ii) the sum of such baseline expendi-  
 18               tures for all such sectors for the fiscal  
 19               year.

20           “(B) BASELINE-PROJECTED MEDICARE  
 21          EXPENDITURES.—In this paragraph, the ‘base-  
 22          line-projected medicare expenditures’ for a sec-  
 23          tor of medicare services—

24               “(i) for fiscal year 1998 is equal to  
 25               fee-for-service expenditures for such sector

during fiscal year 1997, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1998 (as specified in the table in subparagraph (C)); and

“(ii) for a subsequent fiscal year is equal to the baseline-projected medicare expenditures under this subparagraph for the sector for the previous fiscal year increased by the baseline annual growth rate for such sector for the fiscal year involved (as specified in such table).

“(C) BASELINE ANNUAL GROWTH RATES.—The following table specifies the baseline annual growth rates for each of the sectors for different fiscal years:

“For the following sector—	Baseline annual growth rates for fiscal year—				
	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services .....	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services .....	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services .....	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care .....	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians’ services .....	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services .....	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies .....	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests .....	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services .....	10.9%	12.0%	11.6%	11.6%	11.8%

“(d) MANNER OF PAYMENT ADJUSTMENT.—

“(1) PAYMENT REDUCTIONS.—

1           “(A) IN GENERAL.—Subject to the suc-  
 2           ceeding provisions of this subsection, the Sec-  
 3           retary shall apply a payment reduction for each  
 4           excess spending sector for a fiscal year in such  
 5           a manner as to—

6                   “(i) make a change in payment rates  
 7                   (to the maximum extent practicable) at the  
 8                   time payment rates are otherwise changed  
 9                   or subject to change for that fiscal year;  
 10                  and

11                  “(ii) provide for the full appropriate  
 12                  adjustment so that the fee-for-service ex-  
 13                  penditures for the sector for the fiscal year  
 14                  will be reduced by 133 $\frac{1}{3}$  percent of the  
 15                  amount of the sector reduction target for  
 16                  that sector.

17           “(B) SECTOR REDUCTION TARGET.—In  
 18           paragraph (1), the ‘sector reduction target’ for  
 19           an excess spending sector for a fiscal year is  
 20           equal to the product of—

21                   “(i) the amount of the excess spend-  
 22                   ing for such sector and year (as defined in  
 23                   subsection (a)(2)); and

24                   “(ii) the ratio of—

1 “(I) the aggregate excess spend-  
 2 ing for the year (as defined in sub-  
 3 section (a)(1)), to

4 “(II) the sum of the amounts of  
 5 the excess spending for all excess  
 6 spending sectors.

7 “(2) TAKING INTO ACCOUNT VOLUME AND  
 8 CASH FLOW.—In providing for an adjustment in  
 9 payments under this subsection for a sector for a  
 10 fiscal year, the Secretary shall take into account (in  
 11 a manner consistent with actuarial projections)—

12 “(A) the impact of such an adjustment on  
 13 the volume or type of services provided in such  
 14 sector (and other sectors), and

15 “(B) the fact that an adjustment may  
 16 apply to items and services furnished in a fiscal  
 17 year (payment for which may occur in a subse-  
 18 quent fiscal year),

19 in a manner that is consistent with assuring that  
 20 total fee-for-services expenditures for each sector for  
 21 the fiscal year will not exceed the allotment under  
 22 subsection (c)(1) for such sector for such year.

23 “(3) PROPORTIONALITY OF REDUCTIONS WITH-  
 24 IN A SECTOR.—In making adjustments under this

1 subsection in payment for items and services in-  
 2 cluded within a sector of medicare services for a fis-  
 3 cal year, the Secretary shall provide for such an ad-  
 4 justment that results (to the maximum extent fea-  
 5 sible) in the same percentage reductions in aggre-  
 6 gate Federal payments under parts A and B for the  
 7 different classes of items and services included with-  
 8 in the sector for the fiscal year.

9 “(4) APPLICATION TO PAYMENTS MADE BASED  
 10 ON PROSPECTIVE PAYMENT RATES DETERMINED ON  
 11 A FISCAL YEAR BASIS.—

12 “(A) IN GENERAL.—In applying subsection  
 13 (a) with respect to items and services for which  
 14 payment is made under part A or B on the  
 15 basis of rates that are established on a prospec-  
 16 tive basis for (and in advance of) a fiscal year,  
 17 the Secretary shall provide for the payment ad-  
 18 justment under such subsection through an ap-  
 19 propriate reduction in such rates established for  
 20 items and services furnished (or, in the case of  
 21 payment for operating costs of inpatient hos-  
 22 pital services of subsection (d) hospitals and  
 23 subsection (d) Puerto Rico hospitals (as defined  
 24 in paragraphs (1)(B) and (9)(A) of section

1 1886(d)), discharges occurring) during such  
 2 year.

3 “(B) DESCRIPTION OF APPLICATION TO  
 4 SPECIFIC SERVICES.—The payment adjustment  
 5 described in subparagraph (A) applies for a fis-  
 6 cal year to at least the following:

7 “(i) UPDATE FACTOR FOR PAYMENT  
 8 FOR OPERATING COSTS OF INPATIENT  
 9 HOSPITAL SERVICES OF PPS HOSPITALS.—  
 10 To the computation of the applicable per-  
 11 centage increase specified in section  
 12 1886(d)(3)(B)(i) for discharges occurring  
 13 in the fiscal year.

14 “(ii) HOME HEALTH SERVICES.—To  
 15 the extent payment amounts for home  
 16 health services are based on per visit pay-  
 17 ment rates under section 1895, to the com-  
 18 putation of the increase in the national per  
 19 visit payment rates established for the year  
 20 under section 1895(b)(2)(B).

21 “(iii) HOSPICE CARE.—To the update  
 22 of payment rates for hospice care under  
 23 section 1814(i) for services furnished dur-  
 24 ing the fiscal year.

1                   “(iv) UPDATE FACTOR FOR PAYMENT  
 2                   OF OPERATING COSTS OF INPATIENT HOS-  
 3                   PITAL SERVICES OF PPS-EXEMPT HOS-  
 4                   PITALS.—To the computation of the target  
 5                   amount under section 1886(b)(3) for dis-  
 6                   charges occurring during the fiscal year.

7                   “(5) APPLICATION TO PAYMENTS MADE BASED  
 8                   ON PROSPECTIVE PAYMENT RATES DETERMINED ON  
 9                   A CALENDAR YEAR BASIS.—

10                   “(A) IN GENERAL.—In applying subsection  
 11                   (a) for a fiscal year with respect to items and  
 12                   services for which payment is made under part  
 13                   A or B on the basis of rates that are estab-  
 14                   lished on a prospective basis for (and in ad-  
 15                   vance of) a calendar year, the Secretary shall  
 16                   provide for the payment adjustment under such  
 17                   subsection through an appropriate reduction in  
 18                   such rates established for items and services  
 19                   furnished at any time during such calendar  
 20                   year as follows:

21                   “(i) For fiscal year 1999, the reduc-  
 22                   tion shall be made for payment rates dur-  
 23                   ing calendar year 1999 in a manner so as  
 24                   to achieve the necessary payment reduc-  
 25                   tions for such fiscal year for items and

1 services furnished during the first 3 quar-  
2 ters of calendar year 1999.

3 “(ii) For a subsequent fiscal year, the  
4 reduction shall be made for payment rates  
5 during the calendar year in which the fis-  
6 cal year ends in a manner so as to achieve  
7 the necessary payment reductions for such  
8 fiscal year for items and services furnished  
9 during the first 3 quarters of the calendar  
10 year, but also taking into account the pay-  
11 ment reductions made in the first quarter  
12 of the fiscal year resulting from payment  
13 reductions made under this paragraph for  
14 the previous calendar year.

15 “(iii) Payment rate reductions ef-  
16 fected under this subparagraph for a cal-  
17 endar year and applicable to the last 3  
18 quarters of the fiscal year in which the cal-  
19 endar year ends shall continue to apply  
20 during the first quarter of the succeeding  
21 fiscal year.

22 “(B) APPLICATION IN SPECIFIC CASES.—

23 The payment adjustment described in subpara-  
24 graph (A) applies for a fiscal year to at least  
25 the following:



1                   “(i) UPDATE IN CONVERSION FACTOR  
2                   FOR PHYSICIANS’ SERVICES.—To the com-  
3                   putation of the conversion factor under  
4                   subsection (d) of section 1848 used in the  
5                   fee schedule established under subsection  
6                   (b) of such section, for items and services  
7                   furnished during the calendar year in  
8                   which the fiscal year ends.

9                   “(ii) PAYMENT RATES FOR OTHER  
10                  HEALTH CARE PROFESSIONALS.—To the  
11                  computation of payments for professional  
12                  services, furnished during the calendar  
13                  year in which the fiscal year ends, of cer-  
14                  tified registered nurse anesthetists under  
15                  section 1833(l), nurse midwives, physician  
16                  assistants, nurse practitioners and clinical  
17                  nurse specialists under section 1833(r),  
18                  clinical psychologists, clinical social work-  
19                  ers, physical or occupational therapists,  
20                  and any other health professionals for  
21                  which payment rates are based (in whole  
22                  or in part) on payments for physicians’  
23                  services.

24                  “(iii) UPDATE IN LABORATORY FEE  
25                  SCHEDULE.—To the computation of the

1 fee schedule amount under section  
2 1833(h)(2) for clinical diagnostic labora-  
3 tory services furnished during the calendar  
4 year in which the fiscal year ends.

5 “(iv) UPDATE IN REASONABLE  
6 CHARGES FOR VACCINES.—To the com-  
7 putation of the reasonable charge for vac-  
8 cines described in section 1861(s)(10) for  
9 vaccines furnished during the calendar  
10 year in which the fiscal year ends.

11 “(v) DURABLE MEDICAL EQUIPMENT-  
12 RELATED ITEMS.—To the computation of  
13 the payment basis under section  
14 1834(a)(1)(B) for covered items described  
15 in section 1834(a)(13), for items furnished  
16 during the calendar year in which the fis-  
17 cal year ends.

18 “(vi) RADIOLOGIST SERVICES.—To  
19 the computation of conversion factors for  
20 radiologist services under section 1834(b),  
21 for services furnished during the calendar  
22 year in which the fiscal year ends.

23 “(vii) SCREENING MAMMOGRAPHY.—  
24 To the computation of payment rates for  
25 screening mammography under section

1 1834(c)(1)(C)(ii), for screening mammog-  
 2 raphy performed during the calendar year  
 3 in which the fiscal year ends.

4 “(viii) PROSTHETICS AND  
 5 ORTHOTICS.—To the computation of the  
 6 amount to be recognized under section  
 7 1834(h) for payment for prosthetic devices  
 8 and orthotics and prosthetics, for items  
 9 furnished during the calendar year in  
 10 which the fiscal year ends.

11 “(ix) SURGICAL DRESSINGS.—To the  
 12 computation of the payment amount re-  
 13 ferred to in section 1834(i)(1)(B) for sur-  
 14 gical dressings, for items furnished during  
 15 the calendar year in which the fiscal year  
 16 ends.

17 “(x) PARENTERAL AND ENTERAL NU-  
 18 TRITION.—To the computation of reason-  
 19 able charge screens for payment for paren-  
 20 teral and enteral nutrition under section  
 21 1834(h), for nutrients furnished during the  
 22 calendar year in which the fiscal year ends.

23 “(xi) AMBULANCE SERVICES.—To the  
 24 computation of limits on reasonable  
 25 charges for ambulance services, for services

1           furnished during the calendar year in  
2           which the fiscal year ends.

3           “(6) APPLICATION TO PAYMENTS MADE BASED  
4           ON COSTS DURING A COST REPORTING PERIOD.—

5           “(A) IN GENERAL.—In applying subsection  
6           (a) for a fiscal year with respect to items and  
7           services for which payment is made under part  
8           A or B on the basis of costs incurred for items  
9           and services in a cost reporting period, the Sec-  
10          retary shall provide for the payment adjustment  
11          under such subsection for a fiscal year through  
12          an appropriate proportional reduction in the  
13          payment for costs for such items and services  
14          incurred at any time during each cost reporting  
15          period any part of which occurs during the fis-  
16          cal year involved, but only (for each such cost  
17          reporting period) in the same proportion as the  
18          fraction of the cost reporting period that occurs  
19          during the fiscal year involved.

20          “(B) APPLICATION IN SPECIFIC CASES.—  
21          The payment adjustment described in subpara-  
22          graph (A) applies for a fiscal year to at least  
23          the following:

24                 “(i) CAPITAL-RELATED COSTS OF  
25                 HOSPITAL SERVICES.—To the computation

1 of payment amounts for inpatient and out-  
2 patient hospital services under sections  
3 1886(g) and 1861(v) for portions of cost  
4 reporting periods occurring during the fis-  
5 cal year.

6 “(ii) OPERATING COSTS FOR PPS-EX-  
7 EMPT HOSPITALS.—To the computation of  
8 payment amounts under section 1886(b)  
9 for operating costs of inpatient hospital  
10 services of PPS-exempt hospitals for por-  
11 tions of cost reporting periods occurring  
12 during the fiscal year.

13 “(iii) DIRECT GRADUATE MEDICAL  
14 EDUCATION.—To the computation of pay-  
15 ment amounts under section 1886(h) for  
16 reasonable costs of direct graduate medical  
17 education costs for portions of cost report-  
18 ing periods occurring during the fiscal  
19 year.

20 “(iv) INPATIENT RURAL PRIMARY  
21 CARE HOSPITAL SERVICES.—To the com-  
22 putation of payment amounts under sec-  
23 tion 1814(l) for inpatient rural primary  
24 care hospital services for portions of cost

1 reporting periods occurring during the fis-  
2 cal year.

3 “(v) EXTENDED CARE SERVICES OF A  
4 SKILLED NURSING FACILITY.—To the com-  
5 putation of payment amounts under sec-  
6 tion 1861(v) for post-hospital extended  
7 care services of a skilled nursing facility  
8 for portions of cost reporting periods oc-  
9 ccurring during the fiscal year.

10 “(vi) REASONABLE COST CON-  
11 TRACTS.—To the computation of payment  
12 amounts under section 1833(a)(1)(A) for  
13 organizations for portions of cost reporting  
14 periods occurring during the fiscal year.

15 “(vii) HOME HEALTH SERVICES.—  
16 Subject to paragraph (4)(B)(ii), for pay-  
17 ment amounts for home health services, for  
18 portions of cost reporting periods occurring  
19 during such fiscal year.

20 “(7) OTHER.—In applying subsection (a) for a  
21 fiscal year with respect to items and services for  
22 which payment is made under part A or B on a  
23 basis not described in a previous paragraph of this  
24 subsection, the Secretary shall provide for the pay-  
25 ment adjustment under such subsection through an

1 appropriate proportional reduction in the payments  
2 (or payment bases for items and services furnished)  
3 during the fiscal year.

4 “(8) ADJUSTMENT OF PAYMENT LIMITS.—The  
5 Secretary shall provide for such proportional adjust-  
6 ment in any limits on payment established under  
7 part A or B for items and services within a sector  
8 as may be appropriate based on (and in order to  
9 properly carry out) the adjustment to the amount of  
10 payment under this subsection in the sector.

11 “(9) REFERENCES TO PAYMENT RATES.—Ex-  
12 cept as the Secretary may provide, any reference in  
13 this title (other than this section) to a payment rate  
14 is deemed a reference to such a rate as adjusted  
15 under this subsection.

16 “(e) PUBLICATION OF DETERMINATIONS; JUDICIAL  
17 REVIEW.—

18 “(1) ONE-TIME PUBLICATION OF SECTORS AND  
19 GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—  
20 Not later than October 1, 1998, the Secretary shall  
21 publish in the Federal Register the classification of  
22 medicare items and services into the sectors of medi-  
23 care services under subsection (b) and the general

1 methodology to be used in applying payment adjust-  
2 ments to the different classes of items and services  
3 within the sectors.

4 “(2) INCLUSION OF INFORMATION IN PRESI-  
5 DENT’S BUDGET.—

6 “(A) IN GENERAL.—With respect to fiscal  
7 years beginning with fiscal year 2001, the  
8 President shall include in the budget submitted  
9 under section 1105 of title 31, United States  
10 Code, information on—

11 “(i) the fee-for-service expenditures,  
12 within each sector, for the second previous  
13 fiscal year, and how such expenditures  
14 compare to the adjusted sector allotment  
15 for that sector for that fiscal year; and

16 “(ii) actual annual growth rates for  
17 fee-for-service expenditures in the different  
18 sectors in the second previous fiscal year.

19 “(B) RECOMMENDATIONS REGARDING  
20 GROWTH FACTORS.—The President may include  
21 in such budget for a fiscal year (beginning with  
22 fiscal year 2000) recommendations regarding  
23 percentages that should be applied (for one or  
24 more fiscal years beginning with that fiscal  
25 year) instead of the baseline annual growth



1 rates under subsection (c)(3)(C). Such rec-  
 2 ommendations shall take into account medically  
 3 appropriate practice patterns.

4 “(3) DETERMINATIONS CONCERNING PAYMENT  
 5 ADJUSTMENTS.—

6 “(A) RECOMMENDATIONS OF COMMIS-  
 7 SIONS.—By not later than March 1 of each  
 8 year (beginning with 1999), the Prospective  
 9 Payment Review Commission and the Physician  
 10 Payment Review Commission shall jointly sub-  
 11 mit to the Secretary and the Congress a report  
 12 that analyzes the previous operation (if any) of  
 13 this section and that includes recommendations  
 14 concerning the manner in which this section  
 15 should be applied for the following fiscal year.

16 “(B) PRELIMINARY NOTICE BY SEC-  
 17 RETARY.—Not later than May 15 preceding the  
 18 beginning of each fiscal year (beginning with  
 19 fiscal year 2000), the Secretary shall publish in  
 20 the Federal Register a notice containing the  
 21 Secretary’s preliminary determination, for each  
 22 sector of medicare services, concerning the fol-  
 23 lowing:

1                   “(i) The projected allotment under  
2                   subsection (c) for such sector for the fiscal  
3                   year.

4                   “(ii) Whether there will be a payment  
5                   adjustment for items and services included  
6                   in such sector for the fiscal year under  
7                   subsection (a).

8                   “(iii) If there will be such an adjust-  
9                   ment, the size of such adjustment and the  
10                  methodology to be used in making such a  
11                  payment adjustment for classes of items  
12                  and services included in such sector.

13                  “(iv) Beginning with fiscal year 2001,  
14                  the fee-for-service expenditures for such  
15                  sector for the second preceding fiscal year.

16                  Such notice shall include an explanation of the  
17                  basis for such determination. Determinations  
18                  under this subparagraph and subparagraph (C)  
19                  shall be based on the best data available at the  
20                  time of such determinations.

21                  “(C) FINAL DETERMINATION.—Not later  
22                  than September 1 preceding the beginning of  
23                  each fiscal year (beginning with fiscal year  
24                  2000), the Secretary shall publish in the Fed-  
25                  eral Register a final determination, for each

1 sector of medicare services, concerning the mat-  
 2 ters described in subparagraph (B) and an ex-  
 3 planation of the reasons for any differences be-  
 4 tween such determination and the preliminary  
 5 determination for such fiscal year published  
 6 under subparagraph (B).

7 “(4) LIMITATION ON ADMINISTRATIVE OR JUDI-  
 8 CIAL REVIEW.—There shall be no administrative or  
 9 judicial review under section 1878 or otherwise of—

10 “(A) the classification of items and serv-  
 11 ices among the sectors of medicare services  
 12 under subsection (b),

13 “(B) the determination of the amounts of  
 14 allotments for the different sectors of medicare  
 15 services under subsection (c),

16 “(C) the determination of the amount (or  
 17 method of application) of any payment adjust-  
 18 ment under subsection (d), or

19 “(D) any adjustment in an allotment ef-  
 20 fected under subsection (g).

21 “(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—  
 22 In this section, the term ‘fee-for-service expenditures’, for  
 23 items and services within a sector of medicare services in  
 24 a fiscal year, means amounts payable for such items and  
 25 services which are furnished during the fiscal year, and—

1           “(1) includes types of expenses otherwise reim-  
 2           bursable under parts A and B (including administra-  
 3           tive costs incurred by organizations described in sec-  
 4           tions 1816 and 1842) with respect to such items and  
 5           services, and

6           “(2) does not include amounts paid under sec-  
 7           tion 1876.

8           “(g) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO  
 9           REFLECT ACTUAL EXPENDITURES.—

10           “(1) DETERMINATIONS.—

11           “(A) IN GENERAL.—If the Secretary esti-  
 12           mates under subsection (e)(3)(B) with respect  
 13           to a particular fiscal year (beginning with fiscal  
 14           year 2000) that—

15                   “(i) the fee-for-service expenditures  
 16                   for all sectors of medicare services for the  
 17                   second preceding fiscal year, exceeded

18                   “(ii) the sum of the adjusted allot-  
 19                   ments for all sectors for such year (as de-  
 20                   fined in paragraph (2)),

21           then the allotment for each final excess spend-  
 22           ing sector (as defined in subparagraph (B)(i))  
 23           for the particular fiscal year shall be reduced by

the look-back sector reduction amount determined under subparagraph (B)(ii) for such sector and year.

“(B) FINAL EXCESS SPENDING SECTORS.—

“(i) IN GENERAL.—In this paragraph, the term ‘final excess spending sector’ means, for a fiscal year, a sector of medicare services for which the Secretary determines under subsection (e)(3)(B) that—

“(I) the fee-for-service expenditures (as defined in subsection (f)) for the fiscal year, exceeded

“(II) the adjusted allotment for such fiscal year.

For purposes of clause (ii), the term ‘final excess spending’ means, for a fiscal year with respect to such a sector, the amount by which the amount described in subclause (I) (for the fiscal year and sector) exceeds the amount described in subclause (II) for such year and sector.

“(ii) LOOK-BACK SECTOR REDUCTION AMOUNT.—In subparagraph (A)(i), the ‘look-back sector reduction amount’ for a

1 final excess spending sector for a fiscal  
2 year is equal to the product of—

3 “(I) the amount of the final ex-  
4 cess spending for such sector and year  
5 (as defined in clause (i)); and

6 “(II) the ratio of—

7 “(a) the aggregate final ex-  
8 cess spending for the year (de-  
9 scribed in subparagraph (A)(i)),  
10 to

11 “(b) the sum of the amounts  
12 of the final excess spending for  
13 all final excess spending sectors.

14 “(2) ADJUSTED ALLOTMENT.—The adjusted al-  
15 lotment under this paragraph for a sector for a fis-  
16 cal year is—

17 “(A) the amount that would be computed  
18 as the allotment under subsection (c) for the  
19 sector for the fiscal year if the actual amount  
20 of payments made in the fiscal year under the  
21 section 1876 in the fiscal year were substituted  
22 for the amount described in subsection  
23 (c)(2)(A)(ii) for that fiscal year,

24 “(B) adjusted to take into account the  
25 amount of any adjustment under paragraph (1)

1           for that fiscal year (based on expenditures in  
2           the second preceding fiscal year).”.

3           (b) REPORT OF TRUSTEES ON GROWTH RATE IN  
4 PART A EXPENDITURES.—Section 1817 (42 U.S.C.  
5 1395i) is amended by adding at the end the following:

6           “(k) Each annual report provided in subsection (b)(2)  
7 shall include information regarding the annual rate of  
8 growth in program expenditures that would be required  
9 to maintain the financial solvency of the Trust Fund and  
10 the extent to which the provisions of section 1894 restrain  
11 the rate of growth of expenditures under this part in order  
12 to achieve such solvency.”.

13 **SEC. 212. MAINTENANCE OF PART B PREMIUM AT CURRENT**  
14 **PERCENTAGE OF PART B PROGRAM COSTS.**

15           (a) IN GENERAL.—Section 1839(e)(1) of the Social  
16 Security Act (42 U.S.C. 1395r(e)(1)) is amended—

17           (1) in subparagraph (A)—

18                   (A) by striking “and prior to January  
19 1999”, and

20                   (B) by inserting “(or, if higher the percent  
21 described in subparagraph (C))” after “50 per-  
22 cent”; and

23           (2) by adding at the end the following:

24           “(C) For purposes of subparagraph (A), the percent  
25 described in this subparagraph is the ratio (expressed as

1 a percent) of the monthly premium established under this  
 2 section for months in 1996 to the monthly actuarial rate  
 3 for enrollees age 65 and over, as determined under sub-  
 4 section (a)(1) and applicable to such months.”.

5 (b) EFFECTIVE DATE.—The amendments made by  
 6 subsection (a) apply to premiums for months beginning  
 7 with January 1997.

8 **TITLE III—PROMOTION OF PRO-**  
 9 **GRAMS OF ALL-INCLUSIVE**  
 10 **CARE FOR THE ELDERLY**  
 11 **(PACE) AND OF SOCIAL**  
 12 **HEALTH MAINTENANCE OR-**  
 13 **GANIZATIONS (SHMOS)**

14 **SEC. 301. DEFINITIONS.**

15 In this title:

16 (1) PACE PROVIDER.—The term “PACE pro-  
 17 vider” means a provider of services—

18 (A) that—

19 (i) has filed an agreement with the  
 20 Secretary under section 1866 of the Social  
 21 Security Act (42 U.S.C. 1395cc);

22 (ii) is eligible to participate in a State  
 23 plan under title XIX of the Social Security  
 24 Act (42 U.S.C. 1396 et seq.); or



1 (iii) is eligible to receive payment for  
 2 such services under any other applicable  
 3 title of the Social Security Act (42 U.S.C.  
 4 301 et seq.); and  
 5 (B) that has had an application approved  
 6 under this title.

7 (2) MEDICAID PROGRAM.—The term “medicaid  
 8 program” means the health care program under title  
 9 XIX of the Social Security Act (42 U.S.C. 1396 et  
 10 seq.).

11 (3) MEDICARE PROGRAM.—The term “medicare  
 12 program” means the health care program under title  
 13 XVIII of the Social Security Act (42 U.S.C. 1395 et  
 14 seq.).

15 **SEC. 302. EXPANDING THE AVAILABILITY OF QUALIFIED**  
 16 **ORGANIZATIONS FOR FRAIL ELDERLY COM-**  
 17 **MUNITY PROJECTS (PROGRAM OF ALL-IN-**  
 18 **CLUSIVE CARE FOR THE ELDERLY (PACE)).**

19 (a) ESTABLISHMENT OF PACE PROVIDER STA-  
 20 TUS.—

21 (1) IN GENERAL.—The Secretary shall establish  
 22 PACE provider status for public and nonprofit com-  
 23 munity-based organizations (including nonprofit  
 24 community-based organizations that are pending  
 25 qualification for such status under section 501(c)(3)

1 of the Internal Revenue Code of 1986) to enable  
2 such organizations to provide comprehensive health  
3 care services of proper quality on a cost-effective,  
4 capitated basis to frail elderly patients at risk of in-  
5 stitutionalization under titles XVIII or XIX of the  
6 Social Security Act (42 U.S.C. 1395 et seq., 1396  
7 et seq.), or under any other applicable title of that  
8 Act. Each of the initial 3 years of such status shall  
9 be conditioned upon annual reapplication for such  
10 status and timely review and approval by the Sec-  
11 retary as to compliance with program requirements.  
12 During the 3-year period of conditional PACE pro-  
13 vider status, the organization may, at its option and  
14 with the approval of the Secretary, or where deter-  
15 mined necessary by the Secretary, institute proce-  
16 dures such as risk-sharing of service costs to allow  
17 the organization to progressively assume full finan-  
18 cial risk. At the conclusion of the initial 3-year pe-  
19 riod, the organization shall undertake full financial  
20 risk for the cost of services provided to enrollees.  
21 Upon successful completion of the 3-year period, an  
22 organization may continue as a PACE provider, not  
23 conditioned upon annual reapplication for such sta-  
24 tus, but must thereafter continue to meet program  
25 requirements.

1           (2) APPROVAL OF APPLICATIONS.—An appro-  
2           priately completed initial application for PACE pro-  
3           vider status and any subsequent reapplication re-  
4           quired under this title is deemed approved unless the  
5           Secretary specifically disapproves it in writing—

6                   (A) not later than 90 days after the date  
7           the completed application is filed in proper  
8           form; or

9                   (B) not later than 90 days after the date  
10          additional information is provided to the Sec-  
11          retary if the Secretary requests reasonable and  
12          substantial additional information during the  
13          90-day period described in subparagraph (A).

14          (3) SOLE AUTHORITY.—The Secretary shall  
15          have sole and exclusive authority from the date of  
16          enactment of this Act to approve or disapprove the  
17          initial or continuing eligibility of an organization to  
18          participate in the program established under this  
19          title.

20          (4) CONSIDERATION OF EXISTING ORGANIZA-  
21          TIONS.—In reviewing an application for PACE pro-  
22          vider status under this title, the Secretary shall—

23                   (A) consider whether any existing organi-  
24          zation already operates as a PACE provider

1 under this title in the proposed service area  
 2 identified in the application; and

3 (B) if the Secretary determines that such  
 4 an organization exists, ensure that the potential  
 5 population of eligible individuals to be served by  
 6 the applicant is reasonably sufficient to sustain  
 7 an additional organization without jeopardizing  
 8 the economic or service viability of any other or-  
 9 ganization operating in that service area.

10 (b) TERMS AND CONDITIONS FOR PROVIDER STA-  
 11 TUS.—

12 (1) IN GENERAL.—Except as otherwise pro-  
 13 vided by law or regulation, the terms and conditions  
 14 of PACE provider status granted pursuant to this  
 15 title (other than terms and conditions specific to re-  
 16 search and demonstration programs) shall be the fol-  
 17 lowing:

18 (A) The terms and conditions of the On  
 19 Lok waiver (referred to in section 603(c) of the  
 20 Social Security Amendments of 1983 (Public  
 21 Law 98–21, 97 Stat. 168) and extended by sec-  
 22 tion 9220 of the Consolidated Omnibus Budget  
 23 Reconciliation Act of 1985 (Public Law 99–  
 24 272, 100 Stat. 183)).

1 (B) The terms and conditions provided  
2 under the Protocol for the Program of All-inclu-  
3 sive Care for the Elderly (PACE), as published  
4 by On Lok, Inc. as of April 14, 1995, and made  
5 generally available—

6 (i) including the components of the  
7 PACE service delivery model that—

8 (I) focus on frail, elderly enroll-  
9 ees who are age 55 or older, who meet  
10 State health status criteria for a nurs-  
11 ing home level of care;

12 (II) provide comprehensive, inte-  
13 grated acute and long-term care serv-  
14 ices, including, at a minimum, all  
15 services covered under the medicare  
16 program and the medicaid program,  
17 without regard to any limitations on  
18 scope, extent, or frequency of service,  
19 and without requirement of deductible  
20 or copayment contributions;

21 (III) follow an interdisciplinary  
22 team approach to care management  
23 and service delivery;

24 (IV) utilize capitated, integrated  
25 financing that allows the organization

1 to pool payments received under the  
2 medicare program, the medicaid pro-  
3 gram, or from private entities or indi-  
4 viduals; and

5 (V) allow the organization to pro-  
6 gressively assume full financial risk;  
7 and

8 (ii) allowing, where appropriate and  
9 with approval from the Secretary or the  
10 State, reasonable flexibility in adapting the  
11 PACE service delivery model (in cases such  
12 as programs operated in rural areas, or al-  
13 lowing for the use of nonstaff physicians)  
14 where such flexibility is not inconsistent  
15 with and would not impair the essential  
16 elements, objectives, and requirements of  
17 the PACE program that are identified in  
18 clause (i).

19 (C) Mandatory reevaluation of an enroll-  
20 ee's eligibility for a nursing home level of care  
21 1 year from the date of the individual's initial  
22 enrollment with a PACE provider, in order to  
23 assure the continued eligibility of enrollees over  
24 time, except that a State may, in accordance  
25 with regulations issued by the Secretary, ease

1 the administrative burden imposed by such a  
2 recertification process in any case where the ad-  
3 vanced age, severity of chronic condition, or de-  
4 gree of impairment of functional capacity of the  
5 enrollee offers no reasonable expectation of im-  
6 provement or significant change in eligibility  
7 during that 1-year period. If a State finds that  
8 an enrollee technically no longer meets the  
9 health status eligibility criteria for a nursing  
10 home level of care, the State may deem the en-  
11 rollee eligible for continued enrollment with the  
12 PACE provider if the State finds, in accordance  
13 with regulations issued by the Secretary, that in  
14 the absence of the care being provided by the  
15 PACE provider, the enrollee reasonably would  
16 be expected to requalify for the program within  
17 the succeeding 6-month period. In the case of  
18 an enrollee that, through the recertification  
19 process is found to be ineligible for continuation  
20 in the program (including ineligible for deemed  
21 eligibility) the PACE provider shall assist the  
22 enrollee by making appropriate referrals and by  
23 making the enrollee's medical records available  
24 to new providers.

(D) A State may, upon notice to the Secretary, modify requirements under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that relate to income or resources for otherwise eligible individuals where such modifications are comparable to modifications previously authorized by the Secretary for a State under a waiver granted prior to December 31, 1996, on behalf of organizations operating sites authorized under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509, 100 Stat. 2063), unless the Secretary formally finds that any such modification is not reasonably comparable to a modification previously authorized for the State under a waiver.

(2) INFORMATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary’s approval of PACE provider status shall not be conditioned upon an organization collecting information for purposes other than operational purposes, including monitoring of cost and quality of care provided, except to the extent, if any, that any such information might have been required of a organization participating under



1           waivers as of December 31, 1996, but such un-  
2           usual requirement may not continue beyond Oc-  
3           tober 1, 1997. Issuance of interim and final  
4           regulations and implementation of this title  
5           shall not be conditioned upon any such informa-  
6           tion. Nothing in the preceding sentence shall be  
7           construed as prohibiting the Secretary, subse-  
8           quent to the collection and review of any such  
9           unusual information, to make necessary modi-  
10          fications, if any, to implementing regulations  
11          for this title. The Secretary shall issue any reg-  
12          ulations required under this title in a timely  
13          manner.

14                (B) RESEARCH.—The Secretary may re-  
15           quire information from an organization operat-  
16           ing as a PACE provider under this title for  
17           purposes of general research or general evalua-  
18           tion, but only if the organization agrees to par-  
19           ticipate in such research or evaluation and the  
20           organization is appropriately compensated for  
21           any expenses incurred, or where such research  
22           is undertaken entirely at the expense of the  
23           Secretary.

24           (c) ELIGIBILITY FOR PROVIDER STATUS.—

1           (1) IN GENERAL.—Upon successful completion  
 2           of the first 3 years as a PACE provider under this  
 3           title (conditioned upon annual review and annual ap-  
 4           proval of a renewal application by the Secretary, as  
 5           provided in subsection (a)(1)), an organization that  
 6           continues to meet the requirements of this title shall  
 7           continue as a PACE provider under any applicable  
 8           title of the Social Security Act (42 U.S.C. 301 et  
 9           seq.), and shall be recognized as such in accordance  
 10          with regulations promulgated by the Secretary, ex-  
 11          cept that such regulations shall not condition such  
 12          recognition upon formal annual review and approval.

13          (2) REQUIREMENTS.—No organization may be  
 14          eligible to be a PACE provider under this title or  
 15          under any applicable title of the Social Security Act  
 16          (42 U.S.C. 301 et seq.) if—

17                (A) the Secretary specifically and formally  
 18                finds that projected reimbursement for such or-  
 19                ganization would not, without any reimburse-  
 20                ment modifications specified in the Secretary’s  
 21                finding, or, in the case of reimbursement under  
 22                the medicaid program, a finding by the State,  
 23                result in payments below the projected costs for  
 24                a comparable population under the medicare  
 25                program, the medicaid program, or under a

1 program operated under any other applicable  
2 title of such Act, or that the care provided by  
3 such organization is significantly deficient; and

4 (B) such projected reimbursement costs or  
5 significant deficiencies in quality of care are not  
6 appropriately adjusted or corrected on a timely  
7 basis (as determined by the Secretary) in ac-  
8 cordance with the specific recommendations for  
9 reimbursement adjustments or corrections in  
10 the quality of service included in the Secretary's  
11 (or the State's, as applicable) formal finding  
12 under subparagraph (A).

13 (d) REIMBURSEMENT.—Notwithstanding any other  
14 provision of law, an organization that is eligible to be a  
15 PACE provider under any applicable title of the Social Se-  
16 curity Act (42 U.S.C. 301 et seq.) as a result of this title,  
17 shall ordinarily be reimbursed on a capitation basis. Any  
18 such organization may provide additional services as  
19 deemed appropriate by the organization for qualified en-  
20 rollees without regard to whether such services are specifi-  
21 cally reimbursable through capitation payments. To the  
22 extent such services, in terms of type or frequency, are  
23 not reimbursable, no payments for such services may be  
24 required of enrollees.

1       (e) APPLICATION TO ON LOK WAIVERS.—The provi-  
 2       sions of this title also shall apply to an organization oper-  
 3       ating under the On Lok waiver described in subsection  
 4       (b)(1)(A).

5       (f) APPLICATION OF INCOME AND RESOURCES  
 6       STANDARDS FOR CERTAIN INSTITUTIONALIZED  
 7       SPOUSES.—Section 1924 of the Social Security Act (42  
 8       U.S.C. 1396r–5) (relating to the treatment of income and  
 9       resources for certain institutionalized spouses) shall apply  
 10      to any individual receiving services from an organization  
 11      operating as a PACE provider under this title.

12      (g) PROVISION OF SERVICES TO ADDITIONAL POPU-  
 13      LATIONS.—Nothing in this title shall prevent any partici-  
 14      pating organization from independently developing distinct  
 15      programs to provide appropriate services to frail popu-  
 16      lations other than the elderly under any provision of law  
 17      other than this title, except where the Secretary finds that  
 18      the provision of such services impairs the ability of the  
 19      organization to provide services under this title.

20      **SEC. 303. APPLICATION OF SPOUSAL IMPOVERISHMENT**  
 21                                      **RULES.**

22      Section 1924(a)(5) of the Social Security Act (42  
 23      U.S.C. 1396r–5(a)(5)) is amended to read as follows:

24                      “(5) APPLICATION TO INDIVIDUALS RECEIVING  
 25      SERVICES FROM CERTAIN ORGANIZATIONS.—This

1 section applies to individuals receiving institutional  
 2 or noninstitutional services from any organization—

3 “(A) operating under a waiver under—

4 “(i) section 603(c) of the Social Secu-  
 5 rity Amendments of 1983 (Public Law 98–  
 6 21, 97 Stat. 168) (as in effect on the day  
 7 before the date of enactment of the Medi-  
 8 care Modernization and Patient Protection  
 9 Act of 1997);

10 “(ii) section 9412(b) of the Omnibus  
 11 Budget Reconciliation Act of 1986 (Public  
 12 Law 99–509, 100 Stat. 2063) (as so in ef-  
 13 fect); or

14 “(iii) section 301 of the Medicare  
 15 Modernization and Patient Protection Act  
 16 of 1997; or

17 “(B) that is a PACE provider under the  
 18 Medicare Modernization and Patient Protection  
 19 Act of 1997.”.

20 **SEC. 304. PERMITTING EXPANSION AND MAKING PERMA-**  
 21 **NENT SHMO WAIVERS.**

22 Notwithstanding any other provision of law, in the  
 23 case of projects described in section 2355(b) of the Deficit  
 24 Reduction Act of 1984 (Public Law 98–369, 98 Stat.  
 25 1103)—

1           (1) there shall be no limitation on the number  
2       of projects that the Secretary may approve under  
3       such section;

4           (2) there shall be no limitation on the number  
5       of individuals that may participate in any such  
6       project;

7           (3) there shall be no limitation on the period of  
8       the waivers under subsection (c) of such section with  
9       respect to such a project so long as the Secretary  
10      continues to find that the project meets the applica-  
11      ble requirements of such section; and

12          (4) the projects shall not be required to submit  
13      research-related reports after completion of the au-  
14      thorized period of the project (determined without  
15      regard to paragraph (3)).

16 **SEC. 305. REPEALS; EFFECTIVE DATE.**

17      (a) REPEALS.—Except as provided in subsection (b),  
18      section 603(c) of the Social Security Amendments of 1983  
19      (Public Law 98–21, 97 Stat. 168), section 9220 of the  
20      Consolidated Omnibus Budget Reconciliation Act of 1985  
21      (Public Law 99–272, 100 Stat. 183), and section 9412(b)  
22      of the Omnibus Budget Reconciliation Act of 1986 (Public  
23      Law 99–509, 100 Stat. 2063) are repealed.

1 (b) REGULATIONS.—Not later than the first day of  
 2 the month that begins 9 months after the date of enact-  
 3 ment of this Act, the Secretary shall issue, implement, and  
 4 make effective interim final regulations applicable to the  
 5 provisions of this title. Until such date or the date that  
 6 interim final regulations applicable to this title are effec-  
 7 tive and implemented, if earlier, the authority for—

8 (1) On Lok and up to 15 demonstration sites,  
 9 as authorized under section 603(c) of the Social Se-  
 10 curity Amendments of 1983 (Public Law 98–21, 97  
 11 Stat. 168) (as in effect on the day before the date  
 12 of enactment of this Act) and extended by section  
 13 9220 of the Consolidated Omnibus Budget Rec-  
 14 onciliation Act of 1985 (Public Law 99–272, 100  
 15 Stat. 183); and

16 (2) demonstration sites under section 9412(b)  
 17 of the Omnibus Budget Reconciliation Act of 1986  
 18 (Public Law 99–509, 100 Stat. 2063) (as so in ef-  
 19 fect),

20 shall remain in effect. Upon issuance and implementation  
 21 of interim final regulations governing PACE providers, On  
 22 Lok and any demonstration site that has completed an  
 23 initial 3-year demonstration period, and which are other-  
 24 wise qualified under such regulations, shall be eligible for

1 PACE provider status without requirement of annual re-  
2 application so long as On Lok and the site comply, as de-  
3 termined by the Secretary in a timely fashion, with appli-  
4 cable program requirements. A demonstration site other-  
5 wise qualified, but which has not completed a 3-year pe-  
6 riod under waivers, shall convert from a waived program  
7 to a PACE provider with such status predicated upon an-  
8 nual review and approval by the Secretary under this title.  
9 Following successful completion, as determined by the  
10 Secretary, of the third year, such site may continue as  
11 a PACE provider not conditioned upon annual reapplica-  
12 tion for such status but must thereafter continue to meet  
13 program requirements.

14 (c) TRANSITION RULE.—Any organization informally  
15 known as a pre-PACE site operating on a capitation basis  
16 under only the medicaid program and which has formally  
17 expressed the intent to move to dual capitation under both  
18 the medicare program and the medicaid program, but  
19 which, as of the date of enactment of this Act, has not  
20 received waivers authorized under section 9412(b) of the  
21 Omnibus Budget Reconciliation Act of 1986 (Public Law  
22 99–509, 100 Stat. 2063), shall be eligible to operate as  
23 a PACE provider on a temporary basis if the organization  
24 applies for such status under the medicare program and  
25 the medicaid program prior to any issuance of interim or



1 final regulations by the Secretary and the organization  
 2 meets the terms and conditions applied to organizations  
 3 operating under demonstration authority provided under  
 4 section 9412(b) of the Omnibus Budget Reconciliation Act  
 5 of 1986 (Public Law 99–509, 100 Stat. 2063) prior to  
 6 the date of enactment of this Act. Upon issuance of in-  
 7 terim or final regulations governing PACE providers, an  
 8 organization operating as a PACE provider under the au-  
 9 thority of this subsection, shall apply for regular PACE  
 10 provider status under this title.

## 11 **TITLE IV—OTHER MEDICARE** 12 **CHANGES**

### 13 **SEC. 401. APPLICATION OF COMPETITIVE ACQUISITION** 14 **PROCESS FOR PART B ITEMS AND SERVICES.**

15 (a) GENERAL RULE.—Part B of title XVIII of the  
 16 Social Security Act is amended by inserting after section  
 17 1846 the following:

18 “COMPETITION ACQUISITION FOR ITEMS AND SERVICES

19 “SEC. 1847. (a) ESTABLISHMENT OF BIDDING  
 20 AREAS.—

21 “(1) IN GENERAL.—The Secretary is authorized  
 22 to establish competitive acquisition areas for the  
 23 purpose of awarding a contract or contracts for the  
 24 furnishing under this part of the items and services  
 25 described in subsection (c) on or after January 1,

1       1997. The Secretary may establish different com-  
2       petitive acquisition areas under this subsection for  
3       different classes of items and services under this  
4       part.

5           “(2) CRITERIA FOR ESTABLISHMENT.—The  
6       competitive acquisition areas established under para-  
7       graph (1) shall be chosen based on the availability  
8       and accessibility of multiple suppliers and the prob-  
9       able savings to be realized by the use of competitive  
10      bidding in the furnishing of items and services in the  
11      area.

12      “(b) AWARDING OF CONTRACTS IN AREAS.—

13           “(1) IN GENERAL.—The Secretary shall con-  
14      duct a competition among individuals and entities  
15      supplying items and services under this part for  
16      each competitive acquisition area established under  
17      subsection (a) for each class of items and services.

18           “(2) CONDITIONS OF COMPETITION.—

19           “(A) SECRETARIAL FLEXIBILITY.—In con-  
20      ducting the competition, the Secretary may pro-  
21      vide, with respect to items and services that are  
22      subject to the competition and are furnished in  
23      the area involved, that—

1           “(i) the selected entity (or entities)  
2           shall be the exclusive supplier (or suppli-  
3           ers) of such items and services in the area,  
4           if such entity (or entities) have the suffi-  
5           cient capacity to provide all such items and  
6           services required in the area under this  
7           part; or

8           “(ii) the amount of payment made  
9           under this part for such items and services  
10          shall be determined based upon the lowest  
11          bid among entities participating in that  
12          competition for all suppliers of such items  
13          and services in the area who agree to ac-  
14          cept such payment amount as payment in  
15          full under this part.

16          “(B) TREATMENT OF RELATED PROFES-  
17          SIONAL SERVICES.—In the case of a competi-  
18          tion relating to diagnostic tests, a bid may not  
19          be accepted in relation to related professional  
20          services unless the services will be furnished by  
21          a physician who is a participating physician or  
22          otherwise agrees to accept payment on an as-  
23          signment-related basis for all such services.

1           “(3) CONDITIONS FOR AWARDING CONTRACT.—

2           The Secretary may not award a contract to any indi-  
3           vidual or entity under the competition conducted  
4           pursuant to paragraph (1) to furnish an item or  
5           service under this part unless the Secretary finds  
6           that the individual or entity—

7                   “(A) meets quality standards specified by  
8                   the Secretary for the furnishing of such item or  
9                   service; and

10                   “(B) in the case of a competition described  
11                   in subsection (b)(2)(A)(i), offers to furnish a  
12                   total quantity of such item or service that is  
13                   sufficient to meet the expected need within the  
14                   competitive acquisition area.

15           “(4) CONTENTS OF CONTRACT.—A contract en-  
16           tered into with an individual or entity under the  
17           competition conducted pursuant to paragraph (1)  
18           shall specify (for all of the items and services within  
19           a class)—

20                   “(A) in the case of a competition described  
21                   in subsection (b)(2)(A)(i), the quantity of items  
22                   and services the entity shall provide; and

23                   “(B) such other terms and conditions as  
24                   the Secretary may require.

1       “(c) SERVICES DESCRIBED.—The items and services  
2 to which the provisions of this section shall apply are as  
3 follows:

4           “(1) Durable medical equipment and related  
5 supplies, including oxygen and oxygen equipment.

6           “(2) Clinical laboratory services.

7           “(3) Prosthetic devices, orthotics, prosthetics,  
8 and related supplies.

9           “(4) Diagnostic tests, including magnetic reso-  
10 nance imaging tests and computerized axial tomog-  
11 raphy scans, including a physician’s interpretation of  
12 the results of diagnostic tests.

13          “(5) Surgical dressings.

14          “(6) Such other items and services for which  
15 the Secretary determines that the use of competitive  
16 acquisition under this section will be appropriate and  
17 cost-effective.”.

18       (b) IMPLEMENTATION OF COMPETITION.—

19           (1) LIMITATION TO SELECTED SUPPLIERS IN  
20 CASE OF EXCLUSIVE COMPETITIONS.—Section  
21 1862(a) of the Social Security Act (42 U.S.C.  
22 1395y(a)) is amended—

23           (A) by striking “or” at the end of para-  
24 graph (14);

1 (B) by striking the period at the end of  
2 paragraph (15) and inserting “; or”; and

3 (C) by inserting after paragraph (15) the  
4 following:

5 “(16) where such expenses are for an item or  
6 service furnished in a competitive acquisition area  
7 (as established by the Secretary under section  
8 1847(a)) pursuant to a competition described in sec-  
9 tion 1847(b)(2)(A)(i) by an individual or entity  
10 other than the supplier with whom the Secretary has  
11 entered into a contract under section 1847(b) for  
12 the furnishing of such item or service in that area,  
13 except in the case of professional services described  
14 in section 1847(c)(4) and in such other cases (such  
15 as an emergency) as the Secretary may specify.”.

16 (2) LIMITATION TO LOWEST BID IN CASE OF  
17 NONEXCLUSIVE COMPETITIONS.—Section 1833(a) of  
18 the Social Security Act (42 U.S.C. 1395l(a)) is  
19 amended—

20 (A) by striking “and” at the end of para-  
21 graph (6);

22 (B) by striking the period at the end of  
23 paragraph (7) and inserting “; and”; and

24 (C) by adding at the end the following:

1           “(8) notwithstanding the previous provisions of  
 2           this subsection, in the case of an item or service  
 3           which is subject to a competition described in section  
 4           1847(b)(2)(A)(ii), 80 percent of the amount deter-  
 5           mined pursuant to the competition.”.

6           (c) EFFECTIVE DATE.—The amendments made by  
 7           this section shall apply to items and services furnished  
 8           under part B of title XVIII of the Social Security Act on  
 9           or after January 1, 1997.

10   **SEC. 402. SIMPLER PROCEDURE FOR INHERENT REASON-**  
 11                           **ABLENESS DETERMINATIONS.**

12           (a) IN GENERAL.—The first sentence of section  
 13           1834(a)(10)(B) of the Social Security Act (42 U.S.C.  
 14           1395m(a)(10)(B)) is amended by striking “paragraphs  
 15           (8) and (9)” and all that follows up to the period at the  
 16           end and inserting “section 1842(b)(8) to covered items  
 17           and suppliers of such items and payments under this sub-  
 18           section as such provisions apply to items and services and  
 19           entities and a reasonable charge under section 1842(b)”.

20           (b) ELIMINATION OF OBSOLETE PROVISIONS.—Sec-  
 21           tion 1842(b) of the Social Security Act (42 U.S.C.  
 22           1395u(b)) is amended—

23                       (1) in paragraph (8)—

24                               (A) by striking subparagraphs (B) and  
 25                               (C), and

1 (B) in subparagraph (A)—

2 (i) by striking “(A)”, and

3 (ii) by redesignating clauses (i) and

4 (ii) as subparagraphs (A) and (B), respec-

5 tively; and

6 (2) by striking paragraph (9).

7 (c) EFFECTIVE DATE.—The amendments made by  
8 this section shall apply to items furnished on or after Jan-  
9 uary 1, 1997.

10 **SEC. 403. PROMOTING ADVANCE DIRECTIVES.**

11 (a) INCLUSION OF DIRECTIVES IN PATIENT’S MEDI-  
12 CAL RECORD.—Section 1866(f)(1)(B) of the Social Secu-  
13 rity Act (42 U.S.C. 1395cc(f)(1)(B)) is amended by in-  
14 serting before the semicolon at the end the following:  
15 “and, if the individual has executed such a directive, to  
16 ensure that a copy of such directive is included in the med-  
17 ical chart for the individual”.

18 (b) ESTABLISHMENT AND DISSEMINATION OF UNI-  
19 FORM NATIONAL FORMS.—Section 1866(f) of the Social  
20 Security Act (42 U.S.C. 1395cc(f)) is amended—

21 (1) in paragraph (1)(A), by striking the semi-  
22 colon at the end and insert a comma and the follow-  
23 ing:

24 “as well as a copy of the national uniform advance  
25 directive form established under paragraph (4)”; and



1 (2) by adding at the end the following:

2 “(4) By January 1, 1997, the Secretary shall estab-  
3 lish minimum standards for advance directives and a na-  
4 tional uniform advance directives form which may be used  
5 in any State.”.

6 (c) HEALTH PLAN INCENTIVES.—Section 1876(c)(8)  
7 of the Social Security Act (42 U.S.C. 1395mm(c)(8)) is  
8 amended by adding at the end the following: “Nothing in  
9 this title shall be construed as preventing such an organi-  
10 zation from encouraging, through education and dissemi-  
11 nation of promotional material and the organization of in-  
12 formation sessions, enrollees to learn about and execute  
13 advance directives.”.

14 (d) INFORMATION CAMPAIGN.—The Secretary shall  
15 provide for an information campaign concerning the exe-  
16 cution and use of advance directives, particularly with re-  
17 spect to individuals eligible for benefits under the medicare  
18 program. Such campaign shall include training of medi-  
19 care hotline personnel concerning the execution and use  
20 of such directives and the availability of community re-  
21 sources.

22 **SEC. 404. ANTIFRAUD EFFORTS.**

23 (a) INCREASED PENALTIES FOR MEDICARE  
24 FRAUD.—

1           (1) OFFENSE.—Part I of title 18, United  
 2       States Code, is amended by inserting after chapter  
 3       50A the following:

4           **“CHAPTER 50B—MEDICARE FRAUD**

“Sec.

“1101. Medicare fraud.

“1102. Penalties.

“1103. Restitution.

5       **“§ 1101. Medicare fraud**

6           “(a) DEFINITION.—In this section, the term ‘health  
 7       care provider’ means—

8                   “(1) a physician, nurse, dentist, therapist, phar-  
 9       macist, or other professional provider of health care;  
 10       and

11                   “(2) a hospital, health maintenance organiza-  
 12       tion, pharmacy, laboratory, clinic, or other health  
 13       care facility or a provider of medical services, medi-  
 14       cal devices, medical equipment, or other medical sup-  
 15       plies.

16           “(b) OFFENSE.—A health care provider that engages  
 17       in conduct constituting an offense under section 1341 or  
 18       1343 of this title for the purpose of or in connection with  
 19       the provision of health care services or supplies or the pay-  
 20       ment therefore or reimbursement of the costs thereof  
 21       under the medicare program under title XVIII of the So-  
 22       cial Security Act, when—

1           “(1) the amount of loss caused by the fraudu-  
2           lent conduct exceeds \$10,000; or

3           “(2) the offender had previously been convicted  
4           of fraud in Federal or State court,  
5 shall be fined under this title, imprisoned in accordance  
6 with section 1102 of this title, or both.

7   **“§ 1102. Penalties**

8           “(a) IN GENERAL.—In the case of an offense under  
9 section 1101 of this title not described in subsection (b)  
10 or (c) of this section, the offender shall be sentenced to  
11 a term of imprisonment of not more than 10 years.

12          “(b)       SERIOUS       PHYSICAL       INJURY       OR  
13 ENDANGERMENT OF LIFE OF PATIENT.—In the case of  
14 an offense under section 1101 of this title that—

15               “(1) caused serious physical injury to a patient;  
16           or

17               “(2) endangered the life of a patient,  
18 the offender shall be sentenced to a term of imprisonment  
19 of not more than 20 years.

20          “(c) DEATH OF PATIENT.—In the case of an offense  
21 under section 1101 of this title that caused the death of  
22 a patient, the offender shall be sentenced to a term of im-  
23 prisonment of not more than life.

1 **“§ 1103. Restitution**

2       “(a) IN GENERAL.—In sentencing a person convicted  
3 of an offense under section 1101 of this title, the court  
4 shall order the offender to pay restitution to the patient  
5 and the Federal Government for economic loss sustained  
6 as a result of the offense.

7       “(b) RESTITUTION PROCEDURE.—Except to the ex-  
8 tent inconsistent with this section, sections 3363 and 3364  
9 of this title apply to restitution made under this section.”.

10           (2) CLERICAL AMENDMENT.—The table of  
11 chapters at the beginning of part I of title 18, Unit-  
12 ed States Code, is amended by inserting after the  
13 item relating to chapter 50A the following:

“50B. Medicare fraud.”.

14       (b) PERMITTING FORFEITURE FOR REAL OR PER-  
15 SONAL PROPERTY DERIVED FROM MEDICARE FRAUD.—  
16 Section 982(a) of title 18, United States Code, is amended  
17 by adding at the end the following:

18       “(6) The court, in imposing sentence on a person con-  
19 victed of an offense under section 1101 of this title that  
20 relates to the medicare program under title XVIII of the  
21 Social Security Act, shall order that the offender forfeit  
22 to the United States any real or personal property con-  
23 stituting or derived from proceeds that the offender ob-  
24 tained directly or indirectly as the result of the offense.”.

1       (c) STUDY ON STANDARDIZATION OF CLAIMS ADMIN-  
2   ISTRATION.—

3           (1) STUDY.—The Secretary shall conduct a  
4       study on the feasibility and desirability of establish-  
5       ing a standardized medicare claims administration  
6       process, implementing other measures to improve  
7       recordkeeping, and taking other appropriate steps to  
8       reduce waste, fraud, and abuse in making payments  
9       under the medicare program.

10          (2) REPORT.—Not later than 1 year after the  
11       date of enactment of this Act, the Secretary shall  
12       submit a report to Congress on the study conducted  
13       under paragraph (1). The Secretary shall include in  
14       the report such recommendations as the Secretary  
15       considers appropriate.

16       (d) REPORT ON CONSOLIDATION OF ANTIFRAUD EF-  
17   FORTS.—Not later than 1 year after the date of enactment  
18   of this Act, the Vice President’s Commission on Reinvent-  
19   ing Government shall submit a report to Congress on the  
20   effectiveness of the current efforts of the Federal Govern-  
21   ment to combat waste, fraud, and abuse in the medicare  
22   program and on whether such efforts would be enhanced  
23   by the establishment of a coordinated, all-payer, multi-  
24   jurisdiction antifraud program.

1 **SEC. 405. HOSPICE BENEFITS.**

2 (a) **RESTRUCTURING OF BENEFIT PERIOD.**—

3 (1) **IN GENERAL.**—Section 1812 of the Social  
 4 Security Act (42 U.S.C. 1395d) is amended in sub-  
 5 sections (a)(4) and (d)(1), by striking “, a subse-  
 6 quent period of 30 days, and a subsequent extension  
 7 period” and inserting “and an unlimited number of  
 8 subsequent periods of 60 days each”.

9 (2) **CONFORMING AMENDMENTS.**—

10 (A) Section 1812 of the Social Security  
 11 Act (42 U.S.C. 1395d) is amended in sub-  
 12 section (d)(2)(B) by striking “90- or 30-day pe-  
 13 riod or a subsequent extension period” and in-  
 14 serting “90-day period or a subsequent 60-day  
 15 period”.

16 (B) Section 1814(a)(7)(A) of the Social  
 17 Security Act (42 U.S.C. 1395f(a)(7)(A)) is  
 18 amended—

19 (i) in clause (i), by inserting “and” at  
 20 the end;

21 (ii) in clause (ii)—

22 (I) by striking “30-day” and in-  
 23 serting “60-day”; and

24 (II) by striking “and” at the end  
 25 and inserting a period; and

26 (iii) by striking clause (iii).

1 (b) AMBULANCE SERVICES, DIAGNOSTIC TESTS,  
 2 CHEMOTHERAPY SERVICES, AND RADIATION THERAPY  
 3 SERVICES INCLUDED IN HOSPICE CARE.—Section  
 4 1861(dd)(1) of the Social Security Act (42 U.S.C.  
 5 1395x(dd)(1)) is amended—

6 (1) in subparagraph (E), by inserting  
 7 “anticancer chemotherapeutic agents and other” be-  
 8 fore “drugs”;

9 (2) in subparagraph (G), by striking “and” at  
 10 the end;

11 (3) in subparagraph (H), by striking the period  
 12 at the end and inserting a comma; and

13 (4) by inserting after subparagraph (H) the fol-  
 14 lowing:

15 “(I) ambulance services,

16 “(J) diagnostic tests, and

17 “(K) radiation therapy services.”.

18 (c) CONTRACTING WITH INDEPENDENT PHYSICIANS  
 19 OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES  
 20 PERMITTED.—Section 1861(dd)(2) of the Social Security  
 21 Act (42 U.S.C. 1395x(dd)(2)) is amended—

22 (1) in subparagraph (A)(ii)(I), by striking  
 23 “(F),”; and

24 (2) in subparagraph (B)(i), by inserting “or  
 25 under contract with” after “employed by”.

1 (d) WAIVER OF CERTAIN STAFFING REQUIREMENTS  
 2 FOR HOSPICE CARE PROGRAMS IN NONURBANIZED  
 3 AREAS.—Section 1861(dd)(5) of the Social Security Act  
 4 (42 U.S.C. 1395x(dd)(5)) is amended—

5 (1) in subparagraph (B), by inserting “or (C)”  
 6 after “subparagraph (A)” each place it appears; and

7 (2) by adding at the end the following:

8 “(C) The Secretary may waive the requirements of  
 9 paragraph (2)(A)(i) and (2)(A)(ii) for an agency or orga-  
 10 nization with respect to the services described in para-  
 11 graph (1)(B) and, with respect to dietary counseling,  
 12 paragraph (1)(H), if such agency or organization—

13 “(i) is located in an area which is not an urban-  
 14 ized area (as defined by the Bureau of Census), and

15 “(ii) demonstrates to the satisfaction of the  
 16 Secretary that the agency or organization has been  
 17 unable, despite diligent efforts, to recruit appro-  
 18 priate personnel.”.

19 (e) LIMITATION ON LIABILITY OF BENEFICIARIES  
 20 AND PROVIDERS FOR CERTAIN HOSPICE COVERAGE DE-  
 21 NIALS.—

22 (1) IN GENERAL.—Section 1879(g) of the So-  
 23 cial Security Act (42 U.S.C. 1395pp(g)) is amend-  
 24 ed—



1 (A) by redesignating paragraphs (1) and  
 2 (2) as subparagraphs (A) and (B), respectively,  
 3 and indenting appropriately;

4 (B) by striking “is,” and inserting “is—”;

5 (C) by making the remaining text of sub-  
 6 section (g), as amended, that follows “is—” a  
 7 new paragraph (1) and indenting such para-  
 8 graph appropriately;

9 (D) by striking the period at the end and  
 10 inserting “; and”; and

11 (E) by adding at the end the following:

12 “(2) with respect to the provision of hospice  
 13 care to an individual, a determination that the indi-  
 14 vidual is not terminally ill.”.

15 (2) WAIVER PERIOD EXTENDED.—Section  
 16 9305(f)(2) of the Omnibus Budget Reconciliation  
 17 Act of 1986 is amended by striking “and before De-  
 18 cember 31, 1995.”.

19 (3) EFFECTIVE DATE.—The amendments made  
 20 by this subsection take effect December 31, 1995.

21 (f) EXTENDING THE PERIOD FOR PHYSICIAN CER-  
 22 TIFICATION OF AN INDIVIDUAL’S TERMINAL ILLNESS.—  
 23 Section 1814(a)(7)(A)(i)(II) of the Social Security Act (42  
 24 U.S.C. 1395f(a)(7)(A)(i)(II)) is amended by striking “,  
 25 not later than 2 days after hospice care is initiated (or,

1 if each certify verbally not later than 2 days after hospice  
 2 care is initiated, not later than 8 days after such care is  
 3 initiated),” and inserting “at the beginning of the period”.

4 (g) EFFECTIVE DATE.—Except as provided in sub-  
 5 section (e)(3), the amendments made by this section apply  
 6 to benefits provided on or after the date of enactment of  
 7 this Act, regardless of whether or not an individual has  
 8 made an election under section 1812(d) of the Social Secu-  
 9 rity Act (42 U.S.C. 1395d(d)) before that date.

10 **SEC. 406. STUDY PROVIDING PHARMACY SERVICES TO**  
 11 **MEDICARE BENEFICIARIES.**

12 (a) STUDY.—The Secretary shall conduct a thorough  
 13 study in order to identify—

14 (1) any cost savings to the medicare program  
 15 under title XVIII of the Social Security Act (42  
 16 U.S.C. 1395 et seq.) resulting from the provision of  
 17 pharmacy services (described in subsection (b)) to  
 18 beneficiaries under that program; and

19 (2) the various methods of payment for those  
 20 pharmacy services, including a fee schedule and a  
 21 resource-based value scale.

22 (b) PHARMACY SERVICES DESCRIBED.—The phar-  
 23 macy services described in this subsection are—

24 (1) consultations with a physician relative to a  
 25 change in an individual’s drug regimen;

1           (2) consultations with a physician which results  
2           in improved compliance with the drug regimen es-  
3           tablished by that physician for certain drugs fre-  
4           quently prescribed to beneficiaries under the medi-  
5           care program; and

6           (3) disease management programs for hyper-  
7           tension, asthma, and other chronic conditions preva-  
8           lent in beneficiaries under the medicare program.

9           (c) RECOMMENDATIONS.—The Secretary shall de-  
10          velop recommendations on—

11           (1) which pharmacy services should be covered  
12          by the medicare program; and

13           (2) the levels at which those services should be  
14          reimbursed by that program.

15          (d) REPORT.—Not later than 2 years after the date  
16          of enactment of this Act, the Secretary shall submit a re-  
17          port to Congress which shall contain a detailed statement  
18          of the findings and conclusions of the Secretary, together  
19          with its recommendations for such legislation and admin-  
20          istrative actions as the Secretary considers appropriate.

21       **SEC. 407. RESPITE BENEFIT.**

22           (a) ENTITLEMENT.—Section 1832(a)(2) of the Social  
23          Security Act (42 U.S.C. 1395k(a)(2)) is amended—

24           (1) by striking “and” at the end of subpara-  
25          graph (I);

1           (2) by striking the period at the end of sub-  
2 paragraph (J) and inserting “; and”; and

3           (3) by adding at the end the following:

4                   “(K) respite services for not more than 32  
5 hours each year.”.

6       (b) CONDITIONS AND LIMITATIONS ON PAYMENT.—

7           (1) PAYMENT RATE.—Section 1833(a)(2) (42  
8 U.S.C. 1395l(a)(2)) is amended by—

9                   (A) in subparagraph (E), by striking  
10 “and” at the end;

11                  (B) in subparagraph (F), by adding “and”  
12 at the end; and

13                  (C) by adding at the end the following:

14                   “(G)(i) with respect to respite services,  
15 payment shall be made at a rate equal to \$7.50  
16 per hour for 1998 and at a rate to be deter-  
17 mined by the Secretary in subsequent years;  
18 and

19                   “(ii) notwithstanding any provisions of sec-  
20 tion 1861(v), in the case of respite services fur-  
21 nished by a home health agency (or other orga-  
22 nization designated by the Secretary pursuant  
23 to regulations), payment to the agency or other  
24 organization for respite services may not exceed  
25 100 percent of the hourly respite allowance

1 times the number of hours of respite for which  
2 the agency authorizes payment;”.

3 (2) CONDITIONS OF PAYMENT.—Section  
4 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

5 (A) by striking “and” at the end of sub-  
6 paragraph (E);

7 (B) by striking the period at the end of  
8 subparagraph (F) and inserting “; and”; and

9 (C) by inserting after subparagraph (F)  
10 the following:

11 “(G) in the case of respite services, the in-  
12 dividual for whom payment is claimed is se-  
13 verely impaired due to irreversible dementia (as  
14 evidenced by a score of 3 or more errors on the  
15 Short Portable Mental Status Questionnaire)  
16 and either needs assistance in at least one out  
17 of five activities of daily living (bathing, dress-  
18 ing, transferring, toileting, and eating) or in at  
19 least 1 out of 4 instrumental activities of daily  
20 living (meal preparation, medication manage-  
21 ment, money management, and telephoning), or  
22 needs constant supervision because of one or  
23 more behavioral problems, as defined by the  
24 Secretary.”.

1           (3) FAMILY DESIGNATION OF RESPITE SERV-  
2       ICES PROVIDER AND CARE GIVER.—Section  
3       1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended by  
4       adding at the end the following: “In the case of res-  
5       pite services that are the subject of the certification  
6       described in subparagraph (G), the entity or individ-  
7       ual providing the care for which respite is sought  
8       shall designate a respite services caregiver either  
9       through a home health agency or (if the Secretary  
10      designates other organizations to provide or arrange  
11      for such services) another organization. The agency  
12      or organization shall determine the amount of res-  
13      pite entitlement remaining in the calendar year and  
14      inform the entity or individual of the extent to which  
15      respite services may be authorized. When services  
16      have been provided, the entity or individual shall in-  
17      form the agency or organization, which shall then  
18      make payment to the caregiver. Where additional  
19      payment is made on behalf of the beneficiary, the  
20      agency or organization shall ensure that the entity  
21      or individual is informed of the limits applicable to  
22      payments for such services. No payment may be  
23      made under this title for respite services if the per-  
24      hour charge to the patient for care by respite aides

1 exceeds by more than \$2 the hourly rates established  
 2 under this title.”.

3 (c) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x)  
 4 is amended—

5 (1) in subsection (m)—

6 (A) by striking “and” at the end of para-  
 7 graph (6);

8 (B) by adding “and” at the end of para-  
 9 graph (7); and

10 (C) by inserting after paragraph (7) the  
 11 following:

12 “(8) respite services as described in subsection  
 13 (oo);”;

14 (2) in subsection (o)—

15 (A) by striking “and” at the end of para-  
 16 graph (6);

17 (B) by adding “and” at the end of para-  
 18 graph (7); and

19 (C) by inserting after paragraph (7) the  
 20 following:

21 “(8) agrees to provide or arrange for respite  
 22 services as described in subsection (oo);”;

23 (3) by adding after subsection (nn) the follow-  
 24 ing:

1       “Respite Services; Respite Aides; Respite Providers

2       “(oo)(1) The term ‘respite services’ means temporary  
3 care provided to individuals who meet the requirements  
4 of section 1835(a)(2) for the purposes of ensuring periodic  
5 time-off for co-resident primary informal caregivers. Al-  
6 though respite providers may provide assistance with per-  
7 sonal care or household maintenance activities, their pri-  
8 mary function is to provide protective supervision for per-  
9 sons with Alzheimer’s and related dementias whose mem-  
10 ory, orientation, judgment, and reasoning abilities have  
11 become so impaired that, for safety’s sake, they require  
12 the constant attention or close physical proximity of an-  
13 other person at all or almost all hours of the day or night.

14       “(2) The term ‘respite aides’ means individuals who  
15 have been designated by the Secretary as qualified to act  
16 as caregivers for purposes of providing the services de-  
17 scribed in paragraph (1). Respite aides may be nurse aides  
18 who meet the requirements of section 1819(b)(5), home  
19 health aides who meet the requirements of section  
20 1891(a)(3), or other individuals licensed by the State or  
21 recognized by the Secretary as having the skills necessary  
22 to provide such services.

23       “(3) The term ‘respite providers’ means organiza-  
24 tions identified by the Secretary in regulations as qualified  
25 to provide or arrange for respite services under this title.



1 The Secretary may establish by regulation such require-  
 2 ments for respite providers as the Secretary determines  
 3 are appropriate.”.

4 (d) PAYMENT FROM SUPPLEMENTARY MEDICAL IN-  
 5 SURANCE TRUST FUND FOR RESPITE SERVICES FUR-  
 6 NISHED TO INDIVIDUALS WITH ONLY HOSPITAL INSUR-  
 7 ANCE COVERAGE.—Section 1812(a) (42 U.S.C. 1395d(a))  
 8 is amended—

9 (1) by striking “and” at the end of paragraph  
 10 (3);

11 (2) by striking the period at the end of para-  
 12 graph (4) and inserting “; and”; and

13 (3) by adding at the end the following:

14 “(5) respite services, as described in section  
 15 1832(a)(2)(K), except that such services shall be  
 16 furnished under the Supplementary Medical Insur-  
 17 ance Program.”.

18 (e) EFFECTIVE DATE.—The amendments made by  
 19 this section shall be effective for services provided in fiscal  
 20 year 2002 and thereafter.

1 **TITLE V—PROSPECTIVE PAY-**  
 2 **MENT FOR HOME HEALTH**  
 3 **SERVICES**

4 **SEC. 501. PAYMENT FOR HOME HEALTH SERVICES.**

5 (a) IN GENERAL.—Title XVIII of the Social Security  
 6 Act (42 U.S.C. 1395 et seq.) (as amended by section 211  
 7 of this Act) is amended by adding at the end the following:

8 “PAYMENT FOR HOME HEALTH SERVICES

9 “SEC. 1895. (a) IN GENERAL.—Notwithstanding sec-  
 10 tion 1861(v), the Secretary shall provide for payments for  
 11 home health services in accordance with a prospective pay-  
 12 ment system as follows:

13 “(1) PER VISIT PAYMENTS.—Subject to sub-  
 14 section (c), the Secretary shall make per visit pay-  
 15 ments to a home health agency in accordance with  
 16 this section for each type of home health service de-  
 17 scribed in paragraph (2) furnished to an individual  
 18 who at the time the service is furnished is under a  
 19 plan of care by the home health agency under this  
 20 title (without regard to whether or not the item or  
 21 service was furnished by the agency or by others  
 22 under arrangement with them made by the agency,  
 23 under any other contracting or consulting arrange-  
 24 ment, or otherwise).

1           “(2) TYPES OF SERVICES.—The types of home  
2           health services described in this paragraph are the  
3           following:

4                   “(A) Part-time or intermittent nursing  
5                   care provided by or under the supervision of a  
6                   registered professional nurse.

7                   “(B) Physical therapy.

8                   “(C) Occupational therapy.

9                   “(D) Speech-language pathology services.

10                   “(E) Medical social services under the di-  
11                   rection of a physician.

12                   “(F) To the extent permitted in regula-  
13                   tions, part-time or intermittent services of a  
14                   home health aide who has successfully com-  
15                   pleted a training program approved by the Sec-  
16                   retary.

17           “(b) ESTABLISHMENT OF PER VISIT RATE FOR  
18           EACH TYPE OF ASSISTANCE.—

19                   “(1) IN GENERAL.—The Secretary shall, sub-  
20                   ject to paragraph (3), establish a per visit payment  
21                   rate for a home health agency in an area (which  
22                   shall be the same area used to determine the area  
23                   wage index applicable to hospitals under section  
24                   1886(d)(3)(E)) for each type of home health service  
25                   described in subsection (a)(2). Such rate shall be

1 equal to the national per visit payment rate deter-  
 2 mined under paragraph (2) for each such type, ex-  
 3 cept that the labor-related portion of that rate shall  
 4 be adjusted by the area wage index applicable under  
 5 section 1886(d)(3)(E) for the area in which the  
 6 agency is located (as determined without regard to  
 7 any reclassification of the area under section  
 8 1886(d)(8)(B) or a decision of the Medicare Geo-  
 9 graphic Classification Review Board or the Secretary  
 10 under section 1886(d)(10) for cost reporting periods  
 11 beginning after October 1, 1996).

12 “(2) NATIONAL PER VISIT PAYMENT RATE.—  
 13 The national per visit payment rate for each type of  
 14 service described in subsection (a)(2)—

15 “(A) for fiscal year 1998, is an amount  
 16 equal to the national average amount reim-  
 17 bursed per visit under this title to home health  
 18 agencies for such type of service (including  
 19 medical supplies) during the most recent 12-  
 20 month cost reporting period ending on or before  
 21 December 31, 1995, updated by the home  
 22 health market basket percentage increase for  
 23 each year before the date in such fiscal year in  
 24 which this section first applies; and

“(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect under this paragraph for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year.

“(3) PAYMENTS ABOVE PER VISIT RATES.—

“(A) ELECTION.—A home health agency may elect to receive per visit payments in excess of the per visit payment rate under paragraph (1) up to the per visit payment limit under subparagraph (B) if the agency can demonstrate to the satisfaction of the Secretary that it can reasonably expect to incur such costs and that total payments will not exceed the agency’s aggregate limit under subsection (c). The Secretary shall further provide for exemptions, exceptions, and adjustments to the per visit payment limit of this section on the same basis as are provided under subsection (c)(3) with respect to the limitations on final payment.

“(B) PER VISIT PAYMENT LIMIT.—For fiscal year 1998, the per visit payment limit under this subparagraph is calculated as established by section 1861(v)(1)(L). For each subsequent

1           year, such payment limit is equal to the limit  
2           for the preceding fiscal year under this sub-  
3           paragraph increased by the home health market  
4           basket index for the fiscal year involved.

5           “(4) HOME HEALTH MARKET BASKET PER-  
6           CENTAGE INCREASE.—For purposes of this sub-  
7           section, the term ‘home health market basket per-  
8           centage increase’ means, with respect to a fiscal  
9           year, a percentage (estimated by the Secretary be-  
10          fore the beginning of the fiscal year) determined and  
11          applied with respect to the types of home health  
12          services described in subsection (a)(2) in the same  
13          manner as the market basket percentage increase  
14          under section 1886(b)(3)(B)(iii) is determined and  
15          applied to inpatient hospital services for discharges  
16          in the fiscal year.

17          “(c) AGGREGATE LIMITS.—

18                 “(1) PHASE I AGGREGATE LIMIT.—

19                         “(A) IN GENERAL.—Before the end of the  
20                         second 12-month period beginning on the effec-  
21                         tive date of this section, except as provided in  
22                         paragraphs (3) and (4), a home health agency  
23                         may not receive aggregate per visit payments

under subsection (a) for such a 12-month period in excess of an amount equal to the product of—

“(i) the number of unduplicated medicare beneficiaries receiving home health services from the agency during the period; and

“(ii) the per patient limit determined for such period.

“(B) ESTABLISHMENT OF PER PATIENT LIMITS FOR INITIAL YEAR.—

“(i) IN GENERAL.—For the initial 12-month period, the per patient limit for an agency is equal to the product of—

“(I) the sum of 75 percent of the updated per visit costs described in clause (ii) for the agency and 25 percent of the regional average described in clause (iii) for the agency; and

“(II) the average annual number of medicare home health agency visits per unduplicated medicare beneficiary for fiscal year 1996.

“(ii) UPDATED PER VISIT COSTS.—  
The updated per visit costs described in

1           this clause, for a home health agency for  
 2           a payment period, is the average per visit  
 3           reasonable costs for home health services  
 4           of the agency, calculated for the base year,  
 5           based on fiscal year 1995 cost per visit,  
 6           updated by the home health market basket  
 7           percentage increase through the payment  
 8           period involved.

9           “(iii) REGIONAL AVERAGE.—The re-  
 10          gional average described in this clause, for  
 11          a home health agency for a payment pe-  
 12          riod, is the average of the updated per visit  
 13          costs described in clause (ii) for the period  
 14          for home health agencies located in the  
 15          same census region in which the agency is  
 16          located.

17          “(C) ESTABLISHMENT OF PER PATIENT  
 18          LIMITS FOR SECOND YEAR.—For the second 12-  
 19          month period, the per patient limit for an agen-  
 20          cy is equal to the product of—

21               “(i) the sum of—

22                       “(I) 50 percent of the updated  
 23                       per visit costs described in subpara-  
 24                       graph (B)(ii) for the agency for the  
 25                       period, and



1 “(II) 50 percent of the regional  
2 average described in subparagraph  
3 (B)(iii) for the agency for the period;  
4 and

5 “(ii) the average annual number of  
6 medicare home health agency visits per  
7 unduplicated medicare beneficiary for fiscal  
8 year 1996.

9 “(D) NEW PROVIDERS AND PROVIDERS  
10 WITHOUT BASE YEAR.—For a new home health  
11 agency or a home health agency for which there  
12 is no base year under subparagraph (B)(ii), the  
13 per patient limit shall be equal to the mean of  
14 these limits applied to home health agencies in  
15 the same census region in which the agency is  
16 located as determined by the Secretary. A home  
17 health agency shall not be treated as a new  
18 home health agency by reason of any corporate  
19 restructuring or change of name.

20 “(2) PHASE II AGGREGATE LIMITS.—

21 “(A) IN GENERAL.—After the end of the  
22 second 12-month period beginning on the effec-  
23 tive date of this section and until the effective

1 date of any episodic prospective payment sys-  
 2 tem (including a system developed under sub-  
 3 section (h)) that is enacted by the Congress, ex-  
 4 cept as provided in paragraphs (3) and (4), a  
 5 home health agency may not receive aggregate  
 6 per visit payments under subsection (a) for a  
 7 12-month payment period in excess of an  
 8 amount equal to the sum of the following:

9 “(i) The sum (for all case-mix cat-  
 10 egories) of the products (determined sepa-  
 11 rately for each such category) of—

12 “(I) the total number of episodes  
 13 for the category for which the agency  
 14 receives payments during the payment  
 15 period, and

16 “(II) the per episode limit deter-  
 17 mined under subparagraph (B) for  
 18 the category and payment year.

19 “(ii) The product of—

20 “(I) the number of unduplicated  
 21 medicare beneficiaries receiving home  
 22 health services from the agency be-  
 23 yond 120 days during the payment  
 24 year, and

1 “(II) the per patient limit for  
 2 services provided beyond 120 days, as  
 3 specified in subparagraph (E).

4 “(B) ESTABLISHMENT OF PER EPISODE  
 5 LIMITS FOR FIRST 120 DAYS.—

6 “(i) IN GENERAL.—The per episode  
 7 limit under this subparagraph for a pay-  
 8 ment year for a case-mix category for the  
 9 area in which a home health agency is lo-  
 10 cated (which shall be the same area used  
 11 to determine the area wage index applica-  
 12 ble to hospitals under section  
 13 1886(d)(3)(E)) is equal to the product  
 14 of—

15 “(I) the mean number of visits  
 16 for each type of home health service  
 17 described in subsection (a)(2) fur-  
 18 nished during an episode of such case-  
 19 mix category in such area during fis-  
 20 cal year 1996; and

21 “(II) the per visit payment rate  
 22 established under subsection (b) for  
 23 such type of home health service for  
 24 the fiscal year for which the deter-  
 25 mination is being made.

1                   “(ii) DETERMINATION OF AREA.—In  
 2                   the case of an area which the Secretary de-  
 3                   termines has an insufficient number of  
 4                   home health agencies to establish an ap-  
 5                   propriate per episode limit under this sub-  
 6                   paragraph, the Secretary may establish an  
 7                   area other than the area used to determine  
 8                   the area wage under section 1886(d)(3)(E)  
 9                   for purposes of establishing an appropriate  
 10                  per episode limit.

11                  “(C) CASE-MIX CATEGORY.—For purposes  
 12                  of this paragraph, the term ‘case-mix category’  
 13                  means each of the 18 case-mix categories estab-  
 14                  lished under the Home Health Agency Prospec-  
 15                  tive Payment Demonstration Project conducted  
 16                  by the Health Care Financing Administration.  
 17                  The Secretary may develop and apply a more  
 18                  accurate methodology for determining case-mix  
 19                  categories subject to prior public notice and  
 20                  comment under section 553 of title 5, United  
 21                  States Code.

22                  “(D) EPISODE.—

23                         “(i) IN GENERAL.—For purposes of  
 24                         this paragraph, the term ‘episode’ means  
 25                         the continuous 120-day period that—

1 “(I) begins on the date of an in-  
 2 dividual’s first visit for a type of home  
 3 health service described in subsection  
 4 (a)(2) for a case-mix category, and

5 “(II) is immediately preceded by  
 6 a 45-day period in which the individ-  
 7 ual did not receive visits for a type of  
 8 home health service described in sub-  
 9 section (a)(2).

10 “(ii) PRORATION OF EPISODE LIMIT  
 11 SPANNING PAYMENT YEARS.—The Sec-  
 12 retary shall provide for such rules as ap-  
 13 propriate to prorate episode limits under  
 14 this paragraph which begin during a pay-  
 15 ment year and end in a subsequent pay-  
 16 ment year.

17 “(E) ESTABLISHMENT OF A PER PATIENT  
 18 ANNUAL LIMIT FOR SERVICES PROVIDED AFTER  
 19 120 DAYS.—

20 “(i) IN GENERAL.—The per patient  
 21 limit for services provided by a home  
 22 health agency after 120 days for a pay-  
 23 ment period is equal to the product of—

24 “(I) the sum of 50 percent of the  
 25 updated per visit costs described in

1 paragraph (1)(B)(ii) for the agency  
 2 and year and 50 percent of the re-  
 3 gional average described in paragraph  
 4 (1)(B)(iii) for the agency and year;  
 5 and

6 “(II) the average annual number  
 7 of medicare home health agency visits  
 8 over 120 days per unduplicated medi-  
 9 care beneficiary for fiscal year 1996.

10 “(ii) NEW PROVIDERS AND PROVID-  
 11 ERS WITHOUT BASE YEAR.—The provisions  
 12 of subparagraph (D) of paragraph (1)  
 13 shall apply with respect to clause (i)(I) in  
 14 the same manner as they apply to subpara-  
 15 graph (B)(ii) of paragraph (1).

16 “(3) EXEMPTIONS AND EXCEPTIONS.—

17 “(A) EXTRAORDINARY COSTS.—The Sec-  
 18 retary shall provide for an exemption from, or  
 19 an exception and adjustment to, at the request  
 20 of the home health agency, the methods under  
 21 this subsection for determining payment limits  
 22 where events beyond the home health agency’s  
 23 control or extraordinary circumstances, includ-  
 24 ing the case mix of such home health agency,

1 create reasonable costs for a payment year  
2 which exceed the applicable payment limits.

3 “(B) OTHER FACTORS.—The Secretary  
4 may provide for such other exemptions from,  
5 and exceptions and adjustments to, such meth-  
6 ods, as the Secretary deems appropriate, as de-  
7 termined by the Secretary.

8 “(C) TIMELY DETERMINATION.—The Sec-  
9 retary shall announce a decision on any request  
10 for an exemption, exception, or adjustment  
11 under this paragraph not later than 120 days  
12 after receiving a completed application from the  
13 home health agency for such exemption, excep-  
14 tion, or adjustment, and shall include in such  
15 decision a detailed explanation of the grounds  
16 on which such request was approved or denied.

17 “(D) LIMITATION.—The cumulative ex-  
18 penditures for exemptions and exceptions under  
19 this paragraph shall not exceed the cumulative  
20 amount that would have been payable under  
21 paragraph (4)(B) if the 10 percent limitation  
22 under clause (ii) of such paragraph did not  
23 apply.

24 “(4) RECONCILIATION OF AMOUNTS.—

1           “(A) PAYMENTS IN EXCESS OF LIMITS.—

2           If a home health agency has received aggregate  
3           per visit payments under subsection (a) for a  
4           fiscal year in excess of the amount determined  
5           under paragraph (1) with respect to such home  
6           health agency for such fiscal year, the Secretary  
7           shall reduce payments under this section to the  
8           home health agency in the following fiscal year  
9           in such manner as the Secretary considers ap-  
10          propriate (including on an installment basis) to  
11          recapture the amount of such excess.

12           “(B) SHARE OF SAVINGS.—

13           “(i) COMPUTATION.—If a home health  
14          agency has received aggregate per visit  
15          payments under subsection (a) for a pay-  
16          ment year in an amount less than the limit  
17          determined under paragraph (1) or (2) (as  
18          applicable) with respect to such home  
19          health agency for such payment year and,  
20          with respect only to paragraphs (1) and  
21          (2)(E), the home health agency has an av-  
22          erage payment per unduplicated medicare  
23          beneficiary at or below 125 percent of the  
24          regional average (described in paragraph



1 (1)(B)(iii) or (2)(E)(iii), respectively), sub-  
2 ject to clause (ii), the Secretary shall pay  
3 such home health agency a payment equal  
4 to 50 percent of the difference between the  
5 aggregate payment and each applicable  
6 limit under paragraphs (1), (2)(B), or  
7 (2)(E).

8 “(ii) LIMITATION.—In no case shall  
9 payments under clause (i) for an agency  
10 for a year exceed 10 percent of the aggre-  
11 gate per visit payments made to the agency  
12 for the year.

13 “(iii) INSTALLMENT PAYMENTS.—The  
14 Secretary may make the payments to a  
15 home health agency under clause (i) during  
16 a payment year on an installment basis  
17 based on the estimated payment that the  
18 agency would be eligible to receive with re-  
19 spect to such payment year.

20 “(d) MEDICAL REVIEW PROCESS.—The Secretary  
21 shall implement a medical review process for the system  
22 of payments described in this section that shall provide  
23 an assessment of the pattern of care furnished to individ-  
24 uals receiving home health services for which payments are

1 made under this section to ensure that such individuals  
2 receive appropriate home health services.

3 “(e) ADJUSTMENTS.—

4 “(1) IN GENERAL.—The Secretary shall provide  
5 for appropriate adjustments to payments to a home  
6 health agency under this section to ensure that the  
7 agency does not engage in the following for the pur-  
8 poses of circumventing the limits:

9 “(A) Discharging patients to another home  
10 health agency or similar provider.

11 “(B) Altering corporate structure or name  
12 to avoid being subject to this section or for the  
13 purpose of increasing payments under this title.

14 “(2) TRACKING OF PATIENTS THAT SWITCH  
15 HOME HEALTH AGENCIES.—

16 “(A) DEVELOPMENT OF SYSTEM.—The  
17 Secretary shall develop a system that tracks  
18 home health patients that receive home health  
19 services described in subsection (a)(2) from  
20 more than 1 home health agency.

21 “(B) ADJUSTMENT OF LIMITS.—The Sec-  
22 retary shall adjust limits under this section to

1 each home health agency that furnishes an indi-  
2 vidual with a type of home health service de-  
3 scribed in subsection (a)(2) to ensure that ag-  
4 gregate payments on behalf of such individual  
5 during such episode do not exceed the amount  
6 that would be paid under this section if the in-  
7 dividual received such services from a single  
8 home health agency.

9 “(3) MONITORING LOW-COST CASES.—

10 “(A) IN GENERAL.—The Secretary shall  
11 develop and implement a system designed to  
12 monitor significant changes in the percentage  
13 distribution of low-cost and high-cost patients  
14 for which home health services are furnished by  
15 a home health agency over such percentage dis-  
16 tribution determined for the agency under sub-  
17 paragraph (B).

18 “(B) DISTRIBUTION.—The Secretary shall  
19 profile home health service patients to deter-  
20 mine the distribution of patients for the pur-  
21 pose of determining regional and national  
22 trends.

23 “(C) LOW-COST AND HIGH-COST PA-  
24 TIENTS.—For purposes of this paragraph, the  
25 Secretary shall define a low-cost and high-cost

1 patient in a manner that provides that a home  
2 health agency has an incentive to be cost-effi-  
3 cient in delivering home health services and  
4 that the volume of such services does not in-  
5 crease as a result of factors other than patient  
6 needs.

7 “(D) REPORT ON ACCESS.—The Secretary  
8 shall report to Congress on an annual basis  
9 findings and recommendations for ensuring ac-  
10 cess to appropriate home health services.

11 “(f) SPECIAL RULE FOR CHRISTIAN SCIENCE PRO-  
12 VIDERS.—

13 “(1) PAYMENT PERMITTED FOR SERVICES.—  
14 Notwithstanding any other provision of this title,  
15 payment shall be made under this title for home  
16 health services furnished by Christian Science pro-  
17 viders who meet applicable requirements of the First  
18 Church of Christ, Scientist, Boston, Massachusetts,  
19 and are certified for purposes of this title under cri-  
20 teria established by the Secretary, in accordance  
21 with a payment methodology established by the Sec-  
22 retary.

1           “(2) EFFECTIVE DATE.—Paragraph (1) shall  
 2       apply to services furnished during cost reporting pe-  
 3       riods which begin after the date on which the Sec-  
 4       retary establishes the payment methodology and the  
 5       certification criteria described in paragraph (1).

6           “(g) REPORT BY MEDICARE PROSPECTIVE PAYMENT  
 7       REVIEW COMMISSION.—During the first 3 years in which  
 8       payments are made under this section, the Medicare Pro-  
 9       spective Payment Review Commission shall annually sub-  
 10      mit a report to Congress on the effectiveness of the pay-  
 11      ment methodology established under this section that shall  
 12      include recommendations regarding the following:

13           “(1) Case-mix and volume increases.

14           “(2) Quality monitoring of home health agency  
 15      practices.

16           “(3) Whether providers of service are ade-  
 17      quately reimbursed.

18           “(4) On the adequacy of the exemptions and ex-  
 19      ceptions to the limits provided under subsection  
 20      (c)(1)(E).

21           “(5) The appropriateness of the methods pro-  
 22      vided under this section to adjust the aggregate lim-  
 23      its and annual payment updates to reflect changes

1 in the mix of services, number of visits, and assign-  
 2 ment to case categories to reflect changing patterns  
 3 of home health care.

4 “(6) The geographic areas used to determine  
 5 the per episode and per patient limits.

6 “(h) DEVELOPMENT OF EPISODIC PROSPECTIVE  
 7 PAYMENT SYSTEM FOR HOME HEALTH SERVICES.—

8 “(1) IN GENERAL.—The Secretary shall develop  
 9 a method of payments for home health services  
 10 under this title in accordance with an episodic pro-  
 11 spective payment system. In developing the system,  
 12 the Secretary shall take into consideration—

13 “(A) the data and processes from sub-  
 14 section (c)(2) that have proven valid and reli-  
 15 able, and

16 “(B) the degree of disruption resulting  
 17 from changing the payment system.

18 “(2) ADDITIONAL CONSIDERATIONS.—The per  
 19 episode amount under the system shall include all  
 20 services covered and paid under home health services  
 21 under this title as of the date of enactment of this  
 22 section, including medical supplies. In defining an  
 23 episode of care under the system, the Secretary shall  
 24 consider an appropriate length of time for an epi-  
 25 sode, the use of services and the number of visits

1 provided within an episode, potential changes in the  
2 mix of services provided within an episode and their  
3 cost, and a general system design that will provide  
4 for continued access to quality services. The per epi-  
5 sode amount shall be based on the most current data  
6 available to the Secretary and shall include consider-  
7 ation of the cost of new regulatory requirements,  
8 changes in technology, and new care practices.

9 “(3) USE OF CASE MIX ADJUSTER.—Under the  
10 system the Secretary shall employ an appropriate  
11 case mix adjuster that explains a significant amount  
12 of the variation in cost.

13 “(4) UPDATES AND LABOR ADJUSTMENT.—  
14 Under the system, the episode payment amount shall  
15 be updated annually by the home health market bas-  
16 ket index and the labor portion of the episode  
17 amount shall be adjusted for geographic differences  
18 in labor-related costs based on the most current hos-  
19 pital wage index.

20 “(5) OUTLIERS.—Under the system the Sec-  
21 retary may designate a payment provision for  
22 outliers, recognizing the need to adjust payments  
23 due to unusual variations in the type or amount of  
24 medically necessary care.

1           “(6) COORDINATION REQUIREMENT.—Under  
2           the system, a home health agency shall be respon-  
3           sible for coordinating all care for a beneficiary under  
4           this title.

5           “(7) INPUT.—The system shall be developed  
6           with input from and coordination with representa-  
7           tives from the home health services industry and  
8           consumers of home health services.

9           “(8) PROPOSAL.—The Secretary shall submit to  
10          Congress a proposal for the system, consistent with  
11          this subsection, not later than 4 years after the date  
12          of enactment of this section.

13          “(9) IMPLEMENTATION.—The system developed  
14          under this subsection shall become effective only  
15          pursuant to an Act of Congress. It is the intent of  
16          Congress that the effective date of the system be not  
17          later than 18 months after enactment of such an  
18          Act.

19          “(i) DEVELOPMENT OF DATA BASE.—Within 60  
20          days after the date of enactment of this section, the Sec-  
21          retary shall initiate the development of a data base upon  
22          which a fair and accurate case mix adjustor, as required  
23          by subsections (c)(2)(C) and (h)(3), can be developed and  
24          implemented. The data base must—



1           “(1) be capable of linking case mix data with  
2           cost and utilization data;

3           “(2) contain data from HCFA Forms 485 and  
4           UB-92;

5           “(3) contain additional data elements sufficient  
6           to support the case-mix categories in subsection  
7           (c)(2)(C); and

8           “(4) contain any additional data elements de-  
9           termined necessary by the Secretary in consultation  
10          with representatives of the home health industry.”.

11          (b) APPEALS TO PROVIDER REIMBURSEMENT RE-  
12          VIEW BOARD.—Section 1878(a) of the Social Security Act  
13          (42 U.S.C. 1395oo(a)) is amended by inserting “, any  
14          home health agency which has received payment pursuant  
15          to section 1895 may obtain a hearing by the Board, with  
16          respect to such payment,” after “subsection (h)”.

17          (c) SUNSET OF REASONABLE COST LIMITATIONS.—  
18          Section 1861(v)(1)(L) of the Social Security Act (42  
19          U.S.C. 1395x(v)(1)(L)) is amended by adding at the end  
20          the following:

21               “(iv) This subparagraph shall apply only to services  
22          furnished by home health agencies before the effective  
23          date of section 1895.”.

24          (d) EFFECTIVE DATE.—The amendments made by  
25          subsections (a) and (c) shall apply to payment for home

1 health services furnished on or after such date (not later  
2 than 6 months after the date of enactment of this Act)  
3 as the Secretary specifies.

4 **SEC. 502. REVIEW BY PEER REVIEW ORGANIZATION OF**  
5 **HOME HEALTH SERVICES.**

6 (a) IN GENERAL.—Section 1154 of the Social Secu-  
7 rity Act (42 U.S.C. 1320c–3) is amended by adding at  
8 the end the following:

9 “(g)(1) Each contract under this part shall require  
10 that the utilization and quality control peer review organi-  
11 zation’s review responsibility pursuant to subsection (a)(1)  
12 will include review of the level of care and quality of serv-  
13 ices provided individuals receiving home health services  
14 pursuant to sections 1812(a)(3) and 1832(a)(2)(A)(i).

15 “(2) If—

16 “(A) a home health agency has determined that  
17 a patient does not meet the conditions for payment  
18 of home health services under section 1814 or sec-  
19 tion 1833,

20 “(B) the home health agency has determined  
21 that a patient no longer requires home health serv-  
22 ices,

1           “(C) the home health agency has determined  
2           that a patient requires a level of care which is incon-  
3           sistent with the care prescribed by the patient’s at-  
4           tending physician, or

5           “(D) the patient has been authorized by the  
6           home health agency to receive a level of care less  
7           than that considered by the patient as appropriate  
8           to meet the patient’s needs,  
9           the home health agency shall provide the patient (or the  
10          patient’s representative) with a notice (meeting the condi-  
11          tions prescribed by the Secretary under section 1879) of  
12          the determination.

13          “(3)(A) If the patient (or patient’s representative)—

14                  “(i) has received a notice under paragraph  
15                  (2), and

16                  “(ii) requests the appropriate peer review  
17                  organization to review the determination,

18          the organization shall conduct a review under sub-  
19          section (a) of the validity of the home health agen-  
20          cy’s determination and shall provide notice (by tele-  
21          phone and in writing) to the patient or representa-  
22          tive and the home health agency and attending phy-  
23          sician involved of the results of the review. Such re-  
24          view shall be conducted regardless of whether the  
25          home health agency will charge for continued home

1 health services or whether the patient will be liable  
2 for payment for such continued care.

3 “(B) If a patient (or a patient’s representative) re-  
4 quests review under subparagraph (A) while the patient  
5 is still a patient of the home health agency and not later  
6 than noon of the first working day after the date the pa-  
7 tient receives the notice under paragraph (2), then—

8 “(i) the home health agency shall provide to the  
9 appropriate peer review organization the records re-  
10 quired to review the determination by the close of  
11 business of such first working day, and

12 “(ii) the peer review organization must provide  
13 the notice under subparagraph (A) by not later than  
14 one full working day after the date the organization  
15 has received the request and such records.

16 “(4) If—

17 “(A) a request is made under paragraph (3)(A)  
18 not later than noon of the first working day after  
19 the date that the patient (or patient’s representa-  
20 tive) receives the notice under paragraph (2), and

21 “(B) the conditions described in section  
22 1879(a)(2) with respect to the patient or representa-  
23 tive are met,

24 the home health agency shall not charge the patient for  
25 home health services furnished before noon of the day

1 after the date the patient or representative receives notice  
2 of the peer review organization's decision.

3 “(5) In any review conducted under paragraph (2)  
4 or (3), the organization shall solicit the views of the pa-  
5 tient involved (or the patient's representative).

6 “(h) The utilization and quality control peer review  
7 organization shall monitor the delivery of home health  
8 services in a manner which includes a review of home  
9 health agencies that present significant variation in utili-  
10 zation.”.

11 (b) HEARING RIGHTS.—Section 1155 of the Social  
12 Security Act (42 U.S.C. 1320c–4) is amended by adding  
13 at the end the following: “Notwithstanding the previous  
14 provisions of this section, any beneficiary receiving home  
15 health services subject to review under section 1154(g),  
16 and the provider, who is dissatisfied with a determination,  
17 shall be entitled to a hearing by the Secretary and to judi-  
18 cial review of any final determination to the same extent  
19 as provided under section 1869.”.

20 (c) ELIMINATION OF CERTAIN FISCAL  
21 INTERMEDIARY RESPONSIBILITIES.—Section 1816(j) of  
22 the Social Security Act (42 U.S.C. 1395h(j)) is amended  
23 by striking “home health services,”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 subsections (a) and (c) shall apply to contract years begin-  
3 ning after the date of enactment of this Act.

4 **SEC. 503. RETROACTIVE REINSTATEMENT OF PRESUMP-**  
5 **TIVE WAIVER OF LIABILITY.**

6 (a) IN GENERAL.—Section 9305(g)(3) of the Omni-  
7 bus Budget Reconciliation Act of 1986, as amended by  
8 section 426(d) of the Medicare Catastrophic Coverage Act  
9 of 1988 and section 4207(b)(3) of the Omnibus Budget  
10 Reconciliation Act of 1990 (as renumbered by section  
11 160(d)(4) of the Social Security Act Amendments of  
12 1994), is amended by striking “December 31, 1995” and  
13 inserting “the date of implementation of a prospective  
14 payment system for home health care services under sec-  
15 tion 1894(h) of the Social Security Act”.

16 (b) PRESUMPTION.—The second sentence of section  
17 9205 of the Consolidated Omnibus Budget Reconciliation  
18 Act of 1985 is amended by striking “December 31, 1995”  
19 and inserting “the date of implementation of a prospective  
20 payment system for home health care services under sec-  
21 tion 1894(h) of such Act”.

1 **TITLE VI—PROSPECTIVE PAY-**  
2 **MENT SYSTEM FOR NURSING**  
3 **FACILITIES**

4 **SEC. 601. DEFINITIONS.**

5 In this title:

6 (1) **ACUITY PAYMENT.**—The term “acuity pay-  
7 ment” means a fixed amount that will be added to  
8 the facility-specific prices for certain resident classes  
9 designated by the Secretary as requiring heavy care.

10 (2) **AGGREGATED RESIDENT INVOICE.**—The  
11 term “aggregated resident invoice” means a com-  
12 pilation of the per resident invoices of a nursing fa-  
13 cility which contain the number of resident days for  
14 each resident and the resident class of each resident  
15 at the nursing facility during a particular month.

16 (3) **ALLOWABLE COSTS.**—The term “allowable  
17 costs” means costs which HCFA has determined to  
18 be necessary for a nursing facility to incur according  
19 to the Provider Reimbursement Manual (in this title  
20 referred to as “HCFA-Pub. 15”).

21 (4) **BASE YEAR.**—The term “base year” means  
22 the most recent cost reporting period (consisting of  
23 a period which is 12 months in length, except for fa-  
24 cilities with new owners, in which case the period is  
25 not less than 4 months and not more than 13

1 months) for which cost data of nursing facilities is  
2 available to be used for the determination of a pro-  
3 spective rate.

4 (5) CASE MIX WEIGHT.—The term “case mix  
5 weight” means the total case mix score of a facility  
6 calculated by multiplying the resident days in each  
7 resident class by the relative weight assigned to each  
8 resident class, and summing the resulting products  
9 across all resident classes.

10 (6) COMPLEX MEDICAL EQUIPMENT.—The term  
11 “complex medical equipment” means items such as  
12 ventilators, intermittent positive pressure breathing  
13 machines, nebulizers, suction pumps, continuous  
14 positive airway pressure devices, and bead beds such  
15 as air fluidized beds.

16 (7) DISTINCT PART NURSING FACILITY.—The  
17 term “distinct part nursing facility” means an insti-  
18 tution which has a distinct part that is certified  
19 under title XVIII of the Social Security Act (42  
20 U.S.C. 1395 et seq.) and meets the requirements of  
21 section 201.1 of the Skilled Nursing Facility Manual  
22 published by HCFA (in this title referred to as  
23 “HCFA-Pub. 12”).



1           (8) EFFICIENCY INCENTIVE.—The term “effi-  
2       ciency incentive” means a payment made to a nurs-  
3       ing facility in recognition of incurring costs below a  
4       prespecified level.

5           (9) FIXED EQUIPMENT.—The term “fixed  
6       equipment” means equipment which meets the defi-  
7       nition of building equipment in section 104.3 of  
8       HCFA-Pub. 15, including attachments to buildings  
9       such as wiring, electrical fixtures, plumbing, ele-  
10      vators, heating systems, and air conditioning sys-  
11      tems.

12          (10) GEOGRAPHIC CEILING.—The term “geo-  
13      graphic ceiling” means a limitation on payments in  
14      any given cost center for nursing facilities in 1 of no  
15      fewer than 8 geographic regions, further subdivided  
16      into rural and urban areas, as designated by the  
17      Secretary.

18          (11) HCFA.—The term “HCFA” means the  
19      Health Care Financing Administration.

20          (12) HEAVY CARE.—The term “heavy care”  
21      means an exceptionally high level of care which the  
22      Secretary has determined is required for residents in  
23      certain resident classes.

24          (13) INDEXED FORWARD.—The term “indexed  
25      forward” means an adjustment made to a per diem

1 rate to account for cost increases due to inflation or  
 2 other factors during an intervening period following  
 3 the base year and projecting such cost increases for  
 4 a future period in which the rate applies. Indexing  
 5 forward under this title shall be determined from the  
 6 midpoint of the base year to the midpoint of the rate  
 7 year.

8 (14) MDS.—The term “MDS” means a resi-  
 9 dent assessment instrument, currently recognized by  
 10 HCFA, any extensions to MDS, and any extensions  
 11 to accommodate subacute care which contain an ap-  
 12 propriate core of assessment items with definitions  
 13 and coding categories needed to comprehensively as-  
 14 sess a nursing facility resident.

15 (15) MAJOR MOVABLE EQUIPMENT.—The term  
 16 “major movable equipment” means equipment that  
 17 meets the definition of major movable equipment in  
 18 section 104.4 of HCFA-Pub. 15.

19 (16) NURSING FACILITY.—The term “nursing  
 20 facility” means an institution that meets the require-  
 21 ments of a “skilled nursing facility” under section  
 22 1819(a) of the Social Security Act (42 U.S.C.  
 23 1395i–3(a)) and of a “nursing facility” under sec-  
 24 tion 1919(a) of that Act (42 U.S.C. 1396r(a)).

1           (17) PER BED LIMIT.—The term “per bed  
2           limit” means a per-bed ceiling on the fair asset value  
3           of a nursing facility for 1 of the geographic regions  
4           designated by the Secretary.

5           (18) PER DIEM RATE.—The term “per diem  
6           rate” refers to a rate of payment for the costs of  
7           covered services for a resident day.

8           (19) RELATIVE WEIGHT.—The term “relative  
9           weight” means the index of the value of the re-  
10          sources required for a given resident class relative to  
11          the value of resources of either a base resident class  
12          or the average of all the resident classes.

13          (20) R.S. MEANS INDEX.—The term “R.S.  
14          Means Index” means the index of the R. S. Means  
15          Company, Inc., specific to commercial or industrial  
16          institutionalized nursing facilities, that is based  
17          upon a survey of prices of common building mate-  
18          rials and wage rates for nursing facility construc-  
19          tion.

20          (21) REBASE.—The term “rebase” means the  
21          process of updating nursing facility cost data for a  
22          subsequent rate year using a more recent base year.

23          (22) RENTAL RATE.—The term “rental rate”  
24          means a percentage that will be multiplied by the

1 fair asset value of property to determine the total  
2 annual rental payment in lieu of property costs.

3 (23) RESIDENT CLASSIFICATION SYSTEM.—The  
4 term “resident classification system” means a sys-  
5 tem that categorizes residents into different resident  
6 classes according to similarity of their assessed con-  
7 dition and required services of the residents.

8 (24) RESIDENT DAY.—The term “resident day”  
9 means the period of services for 1 resident, regard-  
10 less of payment source, for 1 continuous 24 hours  
11 of services. The day of admission of the resident  
12 constitutes a resident day but the day of discharge  
13 does not constitute a resident day. Bed hold days  
14 are not to be considered resident days, and bed hold  
15 day revenues are not to be offset.

16 (25) RESOURCE UTILIZATION GROUPS, VERSION  
17 III.—The term “Resource Utilization Groups, Ver-  
18 sion III” (in this title referred to as “RUG–III”) re-  
19 fers to a category-based resident classification sys-  
20 tem used to classify nursing facility residents into  
21 mutually exclusive RUG–III groups. Residents in  
22 each RUG–III group utilize similar quantities and  
23 patterns of resources.

24 (26) SECRETARY.—The term “Secretary”  
25 means the Secretary of Health and Human Services.

1           (27) SUBACUTE CARE.—The term “subacute  
2       care” means comprehensive inpatient care designed  
3       for an individual that has an acute illness, injury, or  
4       exacerbation of a disease process. The care is goal  
5       oriented treatment rendered immediately after, or  
6       instead of, acute hospitalization to treat 1 or more  
7       specific active complex medical conditions or to ad-  
8       minister 1 or more technically complex treatments,  
9       in the context of a person’s underlying long-term  
10      conditions and overall situation. In most cases, the  
11      individual’s condition is such that the care does not  
12      depend heavily on high technology monitoring or  
13      complex diagnostic procedures. Subacute care re-  
14      quires the coordinated services of an interdiscipli-  
15      nary team including physicians, nurses, and other  
16      relevant professional disciplines, who are trained and  
17      knowledgeable to assess and manage these specific  
18      conditions and perform the necessary procedures.  
19      Subacute care is given as part of a specifically de-  
20      fined program, regardless of the site. Subacute care  
21      is generally more intensive than traditional nursing  
22      facility care and less than acute care. It requires fre-  
23      quent (daily to weekly) recurrent patient assessment  
24      and review of the clinical course and treatment plan  
25      for a limited (several days to several months) time

1 period, until the condition is stabilized or a predeter-  
2 mined treatment course is completed.

3 **SEC. 602. PAYMENT OBJECTIVES.**

4 Payment rates under the Prospective Payment Sys-  
5 tem for nursing facilities shall reflect the following objec-  
6 tives:

7 (1) To maintain an equitable and fair balance  
8 between cost containment and quality of care in  
9 nursing facilities.

10 (2) To encourage nursing facilities to admit  
11 residents without regard to such residents' source of  
12 payment.

13 (3) To provide an incentive to nursing facilities  
14 to admit and provide care to persons in need of com-  
15 paratively greater care, including those in need of  
16 subacute care.

17 (4) To maintain administrative simplicity, for  
18 both nursing facilities and the Secretary.

19 (5) To encourage investment in buildings and  
20 improvements to nursing facilities (capital forma-  
21 tion) as necessary to maintain quality and access.

22 **SEC. 603. POWERS AND DUTIES OF THE SECRETARY.**

23 (a) RULES AND REGULATIONS.—The Secretary shall  
24 establish by regulation all rules and regulations necessary  
25 for implementation of this title. The rates determined

1 under this title shall be determined in a budget neutral  
 2 manner and shall reflect the objectives described in section  
 3 602 of this title.

4 (b) FILING REQUIREMENTS.—The Secretary may re-  
 5 quire that each nursing facility file such data, statistics,  
 6 schedules, or information as required to enable the Sec-  
 7 retary to implement this title.

8 **SEC. 604. RELATIONSHIP TO TITLE XVIII OF THE SOCIAL**  
 9 **SECURITY ACT.**

10 (a) IN GENERAL.—No provision in this title shall re-  
 11 place, or otherwise affect, the skilled nursing facility bene-  
 12 fit under title XVIII of the Social Security Act (42 U.S.C.  
 13 1395 et seq.).

14 (b) PROVISIONS OF HCFA-15.—The provisions of  
 15 HCFA-Pub. 15 shall apply to the determination of allow-  
 16 able costs under this title except to the extent that such  
 17 provisions conflict with any other provision in this title.

18 **SEC. 605. ESTABLISHMENT OF RESIDENT CLASSIFICATION**  
 19 **SYSTEM.**

20 (a) IN GENERAL.—

21 (1) ESTABLISHMENT.—The Secretary shall es-  
 22 tablish a resident classification system which shall  
 23 group residents into classes according to similarity  
 24 of their assessed condition and required services.

1           (2) MODEL FOR SYSTEM.—The resident classi-  
2       fication system shall be modelled after the RUG-III  
3       system and all updated versions of that system, and  
4       shall be expanded into subacute categories and costs  
5       of care.

6           (3) REFLECTIVE OF CERTAIN TIME AND  
7       COSTS.—The resident classification system shall re-  
8       flect of the necessary professional and paraprofes-  
9       sional nursing staff time and costs required to ad-  
10      dress the care needs of nursing facility residents.

11      (b) RELATIVE WEIGHT FOR EACH RESIDENT  
12      CLASS.—

13           (1) IN GENERAL.—The Secretary shall assign a  
14      relative weight for each resident class based on the  
15      relative value of the resources required for each resi-  
16      dent class. If the Secretary determines it to be ap-  
17      propriate, the assignment of relative weights for  
18      resident classes shall be developed for each geo-  
19      graphic region as determined in accordance with  
20      subsection (c).

21           (2) UTILIZATION OF MDSS.—In assigning the  
22      relative weights of the resident classes in a geo-  
23      graphic region, the Secretary shall utilize informa-  
24      tion derived from the most recent MDSs of all the  
25      nursing facilities in a geographic region.



1           (3) RECALIBRATED EVERY 3 YEARS.—Every 3  
 2       years the Secretary shall recalibrate the relative  
 3       weights of the resident classes in each geographic re-  
 4       gion based on any changes in the cost or amount of  
 5       resources required for the care of a resident in the  
 6       resident class.

7       (c) GEOGRAPHIC REGIONS; PEER GROUPINGS.—

8           (1) GEOGRAPHIC REGIONS.—The Secretary  
 9       shall designate at least 3 geographic regions for the  
 10      total United States. Within each geographic region,  
 11      the Secretary shall take appropriate account of vari-  
 12      ations in cost between urban and rural areas.

13          (2) PEER GROUPING.—The Secretary shall en-  
 14      sure that there are no peer grouping of nursing fa-  
 15      cilities based on facility size or whether the nursing  
 16      facilities are hospital-based or not.

17 **SEC. 606. COST CENTERS FOR NURSING FACILITY PAY-**  
 18 **MENT.**

19       (a) PAYMENT RATES.—Consistent with the objectives  
 20      described in section 602 of this title, the Secretary shall  
 21      determine payment rates for nursing facilities using the  
 22      following cost/service groupings:

23           (1) The nursing service cost center shall include  
 24      salaries and wages for the Director of Nursing, qual-  
 25      ity assurance nurses, registered nurses, licensed

1 practical nurses, nurse aides (including wages relat-  
2 ed to initial and ongoing nurse aid training and  
3 other ongoing or periodic training costs incurred by  
4 nursing personnel), contract nursing, fringe benefits  
5 and payroll taxes associated therewith, medical  
6 records, and nursing supplies.

7 (2) The administrative and general cost center  
8 shall include all expenses (including salaries, bene-  
9 fits, and other costs) related to administration, plant  
10 operation, maintenance and repair, housekeeping, di-  
11 etary (excluding raw food), central services and sup-  
12 ply (excluding medical or nursing supplies), laundry,  
13 and social services, excluding overhead allocations to  
14 ancillary services.

15 (3) Ancillary services that are paid on a fee-for-  
16 service basis shall include physical therapy, occupa-  
17 tional therapy, speech therapy, respiratory therapy,  
18 and hyperalimentation. The fee-for-service ancillary  
19 service payments under part A of title XVIII of the  
20 Social Security Act (42 U.S.C. 1395 et seq.) shall  
21 not affect the reimbursement of ancillary services  
22 under part B of title XVIII of that Act (42 U.S.C.  
23 1395j et seq.).

24 (4) The cost center for selected ancillary serv-  
25 ices and other costs shall include drugs, raw food,

1 IV therapy, x-ray services, laboratory services, prop-  
 2 erty tax, property insurance, and all other costs not  
 3 included in the other 4 cost-of-service groupings.

4 (5) The property cost center shall include de-  
 5 preciation on the buildings and fixed equipment,  
 6 major movable equipment, motor vehicles, land im-  
 7 provements, amortization of leasehold improvements,  
 8 lease acquisition costs, capital leases, interest on  
 9 capital indebtedness, mortgage interest, lease costs,  
 10 and equipment rental expense.

11 (b) PER DIEM RATE.—The Secretary shall pay nurs-  
 12 ing facilities a prospective, facility-specific, per diem rate  
 13 based on the sum of the per diem rates established for  
 14 the nursing service, administrative and general, and prop-  
 15 erty cost centers as determined in accordance with sec-  
 16 tions 528, 529, and 532.

17 (c) FACILITY-SPECIFIC PROSPECTIVE RATE.—The  
 18 Secretary shall pay nursing facilities a facility-specific pro-  
 19 spective rate for each unit of the fee-for-service ancillary  
 20 services as determined in accordance with section 610 of  
 21 this title.

22 (d) REIMBURSEMENT FOR SELECTIVE ANCILLARY  
 23 SERVICES.—Nursing facilities shall be reimbursed by the  
 24 Secretary for selected ancillary services and other costs on

1 a retrospective basis in accordance with section 611 of this  
2 title.

3 **SEC. 607. RESIDENT ASSESSMENT.**

4 (a) IN GENERAL.—In order to be eligible for pay-  
5 ments under this title, a nursing facility shall perform a  
6 resident assessment in accordance with section 1819(b)(3)  
7 of the Social Security Act (42 U.S.C. 1395i–3(b)(3)) with-  
8 in 14 days of admission of the resident and at such other  
9 times as required by that section.

10 (b) RESIDENT CLASS.—The resident assessment  
11 shall be used to determine the resident class of each resi-  
12 dent in the nursing facility for purposes of determining  
13 the per diem rate for the nursing service cost center in  
14 accordance with section 608 of this title.

15 **SEC. 608. THE PER DIEM RATE FOR NURSING SERVICE**  
16 **COSTS.**

17 (a) IN GENERAL.—

18 (1) NURSING SERVICE COST CENTER RATE.—  
19 The Secretary shall calculate the nursing service  
20 cost center rate using a prospective, facility-specific  
21 per diem rate based on the nursing facility's case-  
22 mix weight and nursing service costs during the base  
23 year.

24 (2) CASE-MIX WEIGHT.—For purposes of para-  
25 graph (1), the case-mix weight of a nursing facility

1 shall be obtained by multiplying the number of resi-  
2 dent days in each resident class at a nursing facility  
3 during the base year by the relative weight assigned  
4 to each resident class in the appropriate geographic  
5 region. Once this calculation is performed for each  
6 resident class in the nursing facility, the sum of  
7 these products shall constitute the case-mix weight  
8 for the nursing facility.

9 (3) FACILITY NURSING UNIT VALUE.—A facility  
10 nursing unit value for the nursing facility for the  
11 base year shall be obtained by dividing the nursing  
12 service costs for the base year, which shall be in-  
13 dexed forward from the midpoint of the base period  
14 to the midpoint of the rate period using the DRI  
15 McGraw-Hill HCFA Nursing Home Without Capital  
16 Market Basket, by the case-mix weight of the nurs-  
17 ing facility for the base year.

18 (4) FACILITY-SPECIFIC NURSING SERVICES  
19 PRICE.—A facility-specific nursing services price for  
20 each resident class shall be obtained by multiplying  
21 the lower of the indexed facility unit value of the  
22 nursing facility during the base year or the geo-  
23 graphic ceiling, as determined in accordance with  
24 subsection (b), by the relative weight of the resident  
25 class.

1           (5) PATIENT CLASSIFICATIONS.—For patient  
2       classifications associated with the use of complex  
3       medical equipment and other specialized, noncus-  
4       tomary equipment (particularly subacute classifica-  
5       tions), the Secretary shall provide for a daily allow-  
6       ance for such equipment based upon the amortized  
7       value of such equipment over the life of the equip-  
8       ment.

9           (6) SELECTED RESIDENT CLASSIFICATIONS.—  
10      For selected resident classifications (particularly  
11      subacute classifications) requiring additional or spe-  
12      cialized medical administrative staff, the Secretary  
13      shall provide for a daily allowance to cover these  
14      costs.

15          (7) DESIGNATION OF CERTAIN RESIDENT  
16      CLASSES.—The Secretary shall designate certain  
17      resident classes, such as subacute resident classes,  
18      as requiring heavy care. An acuity payment of 3 per-  
19      cent of the facility-specific nursing services price  
20      shall be added to the facility-specific price for each  
21      resident that the Secretary has designated as requir-  
22      ing heavy care.

23          (8) PER DIEM RATE.—The per diem rate for  
24      the nursing service cost center for each resident in

1 a resident class shall constitute the facility-specific  
 2 price, plus the acuity payment where appropriate.

3 (9) PER DIEM RATE REBASED ANNUALLY.—

4 The Secretary shall annually rebate the per diem  
 5 rate for the nursing service cost center, including the  
 6 facility-specific price and the acuity payment.

7 (10) PAYMENT.—To determine the payment  
 8 amount to a nursing facility for the nursing service  
 9 cost center, the Secretary shall multiply the per  
 10 diem rate (including the acuity payment) for a resi-  
 11 dent class by the number of resident days for each  
 12 resident class based on aggregated resident invoices  
 13 which each nursing facility shall submit on a month-  
 14 ly basis.

15 (b) GEOGRAPHIC CEILING.—

16 (1) FACILITY UNIT VALUE.—The facility unit  
 17 value identified in subsection (a)(3) shall be sub-  
 18 jected to geographic ceilings established for the geo-  
 19 graphic regions designated by the Secretary in sec-  
 20 tion 605 of this title.

21 (2) DETERMINATION.—

22 (A) IN GENERAL.—The Secretary shall de-  
 23 termine the geographic ceiling by creating an  
 24 array of indexed facility unit values in a geo-  
 25 graphic region from lowest to highest. Based on

1           this array, the Secretary shall identify a fixed  
2           proportion between the indexed facility unit  
3           value of the nursing facility which contained the  
4           medianth resident day in the array (except as  
5           provided in subsection (b)(4) of this section)  
6           and the indexed facility unit value of the nurs-  
7           ing facility which contained the 95th percentile  
8           resident day in that array during the first year  
9           of operation of the Prospective Payment System  
10          for nursing facilities. The fixed proportion shall  
11          remain the same in subsequent years.

12                 (B) SUBSEQUENT YEARS.—To obtain the  
13           geographic ceiling on the indexed facility unit  
14           value for nursing facilities in a geographic re-  
15           gion in each subsequent year, the fixed propor-  
16           tion identified pursuant to subparagraph (A)  
17           shall be multiplied by the indexed facility unit  
18           value of the nursing facility which contained the  
19           medianth resident day in the array of facility  
20           unit values for the geographic region during the  
21           base year.

22                 (3) EXCLUSIONS FROM DETERMINATION.—For  
23          purposes of determining the geographic ceiling for a



1 nursing service cost center, the Secretary shall ex-  
2 clude low volume and new nursing facilities (as de-  
3 fined in section 614 of this title).

4 (c) EXCEPTIONS TO GEOGRAPHIC CEILING.—The  
5 Secretary shall establish by regulation procedures for al-  
6 lowing exceptions to the geographic ceiling imposed on a  
7 nursing service cost center. The procedure shall permit ex-  
8 ceptions based on the following factors:

9 (1) Local supply or labor shortages which sub-  
10 stantially increase costs to specific nursing facilities.

11 (2) Higher per resident day usage of contract  
12 nursing personnel, if utilization of contract nursing  
13 personnel is warranted by local circumstances and  
14 the provider has taken all reasonable measures to  
15 minimize contract personnel expense.

16 (3) Extraordinarily low proportion of distinct  
17 part nursing facilities in a geographic region result-  
18 ing in a geographic ceiling that unfairly restricts the  
19 reimbursement of distinct part facilities.

20 (4) Regulatory changes that increase costs to  
21 only a subset of the nursing facility industry.

22 (5) The offering of a new institutional health  
23 service or treatment program by a nursing facility  
24 (in order to account for initial startup costs).

1 (6) Disproportionate usage of part-time employ-  
 2 ees, where adequate numbers of full-time employees  
 3 cannot reasonably be obtained.

4 (7) Other cost producing factors specified by  
 5 the Secretary in regulations that are specific to a  
 6 subset of facilities in a geographic region (except  
 7 case-mix variation).

8 **SEC. 609. THE PER DIEM RATE FOR ADMINISTRATIVE AND**  
 9 **GENERAL COSTS.**

10 (a) IN GENERAL.—

11 (1) PAYMENT.—The Secretary shall make pay-  
 12 ments for the administrative and general cost center  
 13 by using a facility-specific, prospective, per diem  
 14 rate.

15 (2) STANDARDS FOR PER DIEM RATE.—The  
 16 Secretary shall assign a per diem rate to a nursing  
 17 facility by applying 2 standards that is calculated as  
 18 follows:

19 (A) STANDARD A.—The Secretary shall de-  
 20 termine a Standard A for each geographic re-  
 21 gion by creating an array of indexed nursing fa-  
 22 cility administrative and general per diem costs  
 23 from lowest to highest. The Secretary shall then  
 24 identify a fixed proportion by dividing the in-  
 25 dexed administrative and general per diem costs

1 of the nursing facility that contains the  
2 medianth resident day of the array (except as  
3 provided in subsection (a)(4)) into the indexed  
4 administrative and general per diem costs of  
5 the nursing facility that contains the 75th per-  
6 centile resident day in that array. Standard A  
7 for each base year shall constitute the product  
8 of this fixed proportion and the administrative  
9 and general indexed per diem costs of the nurs-  
10 ing facility that contains the medianth resident  
11 day in the array of such costs during the base  
12 year.

13 (B) STANDARD B.—The Secretary shall  
14 determine a Standard B for each geographic re-  
15 gion by using the same calculation as in sub-  
16 paragraph (A) except that the fixed proportion  
17 shall use the indexed administrative and general  
18 costs of the nursing facility containing the 85th  
19 percentile, rather than the 75th percentile, resi-  
20 dent day in the array of such costs.

21 (3) GEOGRAPHIC REGIONS.—The Secretary  
22 shall use the geographic regions identified in section  
23 605(c) of this title for purposes of determining  
24 Standards A and B.

1           (4) EXCLUSION.—The Secretary shall exclude  
2       low volume and new nursing facilities (as defined in  
3       section 614 of this title) for purposes of determining  
4       Standard A and Standard B.

5           (5) PER DIEM RATE.—To determine a nursing  
6       facility's per diem rate for the administrative and  
7       general cost center, Standards A and B shall be ap-  
8       plied to a nursing facility's administrative and gen-  
9       eral per diem costs, indexed forward using the DRI  
10      McGraw-Hill HCFA Nursing Home Without Capital  
11      Market Basket, as follows:

12           (A) Each nursing facility having indexed  
13       costs which are below the median shall be as-  
14       signed a rate equal to their individual indexed  
15       costs plus an “efficiency incentive” equal to  $\frac{1}{2}$   
16       of the difference between the median and  
17       Standard A.

18           (B) Each nursing facility having indexed  
19       costs which are below Standard A but are equal  
20       to or exceed the median shall be assigned a per  
21       diem rate equal to their individual indexed costs  
22       plus an “efficiency incentive” equal to  $\frac{1}{2}$  of the  
23       difference between the nursing facility's indexed  
24       costs and Standard A.

1           (C) Each nursing facility having indexed  
2 costs which are between Standard A and Stand-  
3 ard B shall be assigned a rate equal to Stand-  
4 ard A plus  $\frac{1}{2}$  of the difference between the  
5 nursing facility's indexed costs and Standard A.

6           (D) Each nursing facility having indexed  
7 costs which exceed Standard B shall be as-  
8 signed a rate as if their costs equaled Standard  
9 B. These nursing facilities shall be assigned a  
10 per diem rate equal to Standard A plus  $\frac{1}{2}$  of  
11 the difference between Standard A and Stand-  
12 ard B.

13           (E) For purposes of subparagraphs (A)  
14 through (D), the median represents the indexed  
15 administrative and general per diem costs of a  
16 nursing facility that contains the medianth resi-  
17 dent day in the array of such costs during the  
18 base year in the geographic region.

19       (b) REBASING.—Not less than annually, the Sec-  
20 retary shall rebase the payment rates for administrative  
21 and general costs.

1 **SEC. 610. PAYMENT FOR FEE-FOR-SERVICE ANCILLARY**  
 2 **SERVICES.**

3 (a) IN GENERAL.—The Secretary shall make pay-  
 4 ments for the ancillary services described in section  
 5 606(a)(3) on a prospective fee-for-service basis.

6 (b) PAYMENT METHODOLOGY.—The Secretary shall  
 7 identify the fee for each of the fee-for-service ancillary  
 8 services for a particular nursing facility by dividing the  
 9 nursing facility's reasonable costs, including overhead allo-  
 10 cated through the cost finding process, of providing each  
 11 particular service, indexed forward using the DRI  
 12 McGraw-Hill HCFA Nursing Home Without Capital Mar-  
 13 ket Basket, by the units of the particular service provided  
 14 by the nursing facility during the cost year.

15 (c) COMPUTATION PERIOD.—The fee for each of the  
 16 fee-for-service ancillary services shall be calculated by the  
 17 Secretary under this title at least once a year for each  
 18 facility and ancillary service.

19 **SEC. 611. REIMBURSEMENT OF SELECTED ANCILLARY**  
 20 **SERVICES AND OTHER COSTS.**

21 (a) IN GENERAL.—Reimbursement of selected ancil-  
 22 lary services and other costs identified in section 606(a)(4)  
 23 of this title shall be reimbursed by the Secretary on a ret-  
 24 rospective basis as pass-through costs, including overhead  
 25 allocated through the cost-finding process.

1 (b) CHARGE-BASED INTERIM RATES.—The Sec-  
 2 retary shall set charge-based interim rates for selected an-  
 3 cillary services and other costs for each nursing facility  
 4 providing such services. Any overpayments or underpay-  
 5 ments resulting from the difference between the interim  
 6 and final settlement rates shall be either refunded by the  
 7 nursing facility or paid to the nursing facility following  
 8 submission of a timely filed medicare cost report.

9 **SEC. 612. PER DIEM PAYMENT FOR PROPERTY COSTS.**

10 (a) IN GENERAL.—The Secretary shall make a per  
 11 diem payment for property costs based on a gross rental  
 12 system. The amount of the payment shall be determined  
 13 as follows:

14 (1) BUILDING AND FIXED EQUIPMENT  
 15 VALUE.—In the case of a new facility in any geo-  
 16 graphic region, the cost for building and fixed equip-  
 17 ment used in determining the gross rental shall be  
 18 equivalent to the median cost of home construction  
 19 in the region (as measured by RS Means). Such cost  
 20 shall then be multiplied by the factor 1.2 to account  
 21 for land and the value of movable equipment. The  
 22 resulting value shall be indexed each year using the  
 23 RS Means Construction Cost Index.

24 (2) AGE.—

1           (A) IN GENERAL.—The gross rental sys-  
2           tem establishes a facility's value based on its  
3           age. The older the facility, the less its value.  
4           Additions, replacements, and renovations shall  
5           be recognized by lowering the age of the facility  
6           and, thus, increasing the facility's value. Exist-  
7           ing facilities, 1 year or older, shall be valued at  
8           the new bed value less 2 percent per year ac-  
9           cording to the "age" of the facility. Facilities  
10          shall not be depreciated to an amount less than  
11          50 percent of the new construction bed value.

12          (B) ADDITION OF BEDS.—The addition of  
13          beds shall require a computation by the Sec-  
14          retary of the weighted average age of the facil-  
15          ity based on the construction dates of the origi-  
16          nal facility and the additions.

17          (C) REPLACEMENT OF BEDS.—The re-  
18          placement of existing beds shall result in an ad-  
19          justment to the age of the facility. A weighted  
20          average age shall be calculated by the Secretary  
21          according to the year of initial construction and  
22          the year of bed replacement. If a facility has a  
23          series of additions or replacements, the Sec-  
24          retary shall assume that the oldest beds are the



ones being replaced when computing the average facility age.

(D) RENOVATIONS OR MAJOR IMPROVEMENTS.—Renovations or major improvements shall be calculated by the Secretary as a bed replacement, except that the value of the bed prior to renovation shall be taken into consideration. To qualify as a bed replacement, the bed being renovated must be at least 10 years old and the renovation or improvements cost must be equal to or greater than the difference between the existing bed value and the value of a new bed. To determine the new adjusted facility age, the number of renovated beds assigned a “new” age is determined by dividing the total cost of renovation by the difference between the existing bed value and the value of the new bed.

(E) STARTUP OF GROSS RENTAL SYSTEM.—To start up the fair rental system, each facility’s bed values shall be determined by the Secretary based on the age of the facility. The determination shall include setting a value for the original beds with adjustments for any additions, bed replacements, and major renovations.

1           For determination of bed values for use in de-  
2           termining the initial rate, the procedures de-  
3           scribed above for determining the values of  
4           original beds, additions, and replacements shall  
5           be used.

6           (3) TOTAL CURRENT VALUE.—The Secretary  
7           shall multiply the per bed value by the number of  
8           beds in the facility to estimate the facility's total  
9           current value.

10          (4) RENTAL FACTOR.—The Secretary shall  
11          apply a rental factor to the facility's total current  
12          value to estimate its annual gross rental value. The  
13          Secretary shall determine the rental factor by using  
14          the Treasury Bond Composite Yield (greater than  
15          10 years) as published in the Federal Reserve Bul-  
16          letin plus a risk premium. A risk premium in the  
17          amount of 3 percentage points shall be added to the  
18          Treasury Yield. The rental factor is multiplied by  
19          the facility's total value, as determined in paragraph  
20          (3), to determine the annual gross rental value.

21          (5) PER DIEM PROPERTY PAYMENT.—The an-  
22          nual gross rental value shall be divided by the Sec-  
23          retary by 90 percent of the facility's annual licensed  
24          bed days during the cost report period to arrive at  
25          the per diem property payment.

1           (6) PER RESIDENT DAY RENTAL RATE.—The  
 2           per resident day rental rate for a newly constructed  
 3           facility during its first year of operation shall be  
 4           based on the total annual rental divided by the  
 5           greater of 50 percent of available resident days or  
 6           actual annualized resident days up to 90 percent of  
 7           annual licensed bed days during the first year of op-  
 8           eration.

9           (b) Facilities in operation prior to the effective date  
 10          of this Act shall receive the per resident day rental or ac-  
 11          tual costs, as determined in accordance with HCFA-Pub.  
 12          15, whichever is greater, except that a nursing facility  
 13          shall be reimbursed the per resident day rental on and  
 14          after the earliest of the following dates:

15               (1) the date upon which the nursing facility  
 16               changes ownership;

17               (2) the date the nursing facility accepts the per  
 18               resident day rental; or

19               (3) the date of the renegotiation of the lease for  
 20               the land or buildings, not including the exercise of  
 21               optional extensions specifically included in the origi-  
 22               nal lease agreement or valid extensions thereof.

23 **SEC. 613. MID-YEAR RATE ADJUSTMENTS.**

24           (a) MID-YEAR ADJUSTMENTS.—The Secretary shall  
 25          establish by regulation a procedure for granting mid-year

1 rate adjustments for the nursing service, administrative  
2 and general, and fee-for-service ancillary services cost cen-  
3 ters.

4 (b) INDUSTRY-WIDE BASIS.—The mid-year rate ad-  
5 justment procedure shall require the Secretary to grant  
6 adjustments on an industry-wide basis, without the need  
7 for nursing facilities to apply for such adjustments, based  
8 on the following circumstances:

9 (1) Statutory or regulatory changes affecting  
10 nursing facilities.

11 (2) Changes to the Federal minimum wage.

12 (3) General labor shortages with high regional  
13 wage impacts.

14 (c) APPLICATION FOR ADJUSTMENT.—The mid-year  
15 rate adjustment procedure shall permit specific facilities  
16 or groups of facilities to apply to the Secretary for an ad-  
17 justment based on the following factors:

18 (1) Local labor shortages.

19 (2) Regulatory changes that apply to only a  
20 subset of the nursing facility industry.

21 (3) Economic conditions created by natural dis-  
22 asters or other events outside of the control of the  
23 provider.

1           (4) Other cost producing factors, except case-  
 2       mix variation, to be specified by the Secretary in  
 3       regulations.

4       (d) REQUIREMENTS FOR APPLICATION FOR ADJUST-  
 5       MENT.—

6           (1) IN GENERAL.—A nursing facility which ap-  
 7       plies for a mid-year rate adjustment pursuant to this  
 8       section shall be required to show that the adjust-  
 9       ment will result in a greater than 2 percent devi-  
 10      ation in the per diem rate for any individual cost  
 11      service center or a deviation of greater than \$5,000  
 12      in the total projected and indexed costs for the rate  
 13      year, whichever is less.

14          (2) COST EXPERIENCE DATA.—A nursing facil-  
 15      ity application for a mid-year rate adjustment must  
 16      be accompanied by recent cost experience data and  
 17      budget projections.

18   **SEC. 614. EXCEPTION TO PAYMENT METHODS FOR NEW**  
 19                           **AND LOW VOLUME NURSING FACILITIES.**

20          (a) DEFINITION OF LOW VOLUME NURSING FACIL-  
 21      ITY.—In this title, the term “low volume nursing facility”  
 22      means a nursing facility having fewer than 2,500 medicare  
 23      part A resident days per year.

24          (b) DEFINITION OF NEW NURSING FACILITY.—In  
 25      this title, the term “new nursing facility” means a newly

1 constructed, licensed, and certified nursing facility or a  
 2 nursing facility that is in its first 3 years of operation as  
 3 a provider of services under part A of the medicare pro-  
 4 gram under title XVIII of the Social Security Act (42  
 5 U.S.C. 1395 et seq.). A nursing facility that has operated  
 6 for more than 3 years but has a change of ownership shall  
 7 not constitute a new facility.

8 (c) OPTION FOR LOW VOLUME NURSING FACILI-  
 9 TIES.—A Low volume nursing facility shall have the op-  
 10 tion of submitting a cost report to the Secretary to receive  
 11 retrospective payment for all of the cost centers, other  
 12 than the property cost center, or accepting a per diem rate  
 13 which shall be based on the sum of—

14 (1) the median indexed resident day facility  
 15 unit value for the appropriate geographic region for  
 16 the nursing service cost center during the base year  
 17 as identified in section 608(b)(2) of this title;

18 (2) the median indexed resident day administra-  
 19 tive and general per diem costs of all nursing facili-  
 20 ties in the appropriate geographic region as identi-  
 21 fied in section 609(a)(5)(E) of this title;

22 (3) the median indexed resident day costs per  
 23 unit of service for fee-for-service ancillary services  
 24 obtained using the cost information from the nurs-  
 25 ing facilities in the appropriate geographic region

1 during the base year, excluding low volume and new  
 2 nursing facilities, and based on an array of such  
 3 costs from lowest to highest; and

4 (4) the median indexed resident day per diem  
 5 costs for selected ancillary services and other costs  
 6 obtained using information from the nursing facili-  
 7 ties in the appropriate geographic region during the  
 8 base year, excluding low volume and new nursing fa-  
 9 cilities, and based on an array of such costs from  
 10 lowest to highest.

11 (d) OPTION FOR NEW NURSING FACILITIES.—New  
 12 nursing facilities shall have the option of being paid by  
 13 the Secretary on a retrospective cost pass-through basis  
 14 for all costs centers, or in accordance with subsection (c).

15 **SEC. 615. APPEAL PROCEDURES.**

16 (a) IN GENERAL.—

17 (1) APPEAL.—Any person or legal entity ag-  
 18 grieved by a decision of the Secretary under this  
 19 title, and which results in an amount in controversy  
 20 of \$10,000 or more, shall have the right to appeal  
 21 such decision directly to the Provider Reimburse-  
 22 ment Review Board (in this section referred to as  
 23 “the Board”) authorized under section 1878 of the  
 24 Social Security Act (42 U.S.C. 1395oo).

1           (2) AMOUNT IN CONTROVERSY.—The \$10,000  
 2           amount in controversy referred to in paragraph (1)  
 3           shall be computed in accordance with 42 C.F.R.  
 4           405.1839.

5           (b) HEARINGS.—Any appeals to and any hearings be-  
 6           fore the Board under this title shall follow the procedures  
 7           under section 1878 of the Social Security Act (42 U.S.C.  
 8           1395oo) and the regulations contained in (42 C.F.R.  
 9           405.1841–1889), except to the extent that they conflict  
 10          with, or are inapplicable on account of, any other provision  
 11          of this title.

12   **SEC. 616. TRANSITION PERIOD.**

13          The Prospective Payment System described in this  
 14          title shall be phased in over a 3 year period using the fol-  
 15          lowing blended rate:

16               (1) For the first year that the provisions of this  
 17               title are in effect, 25 percent of the payment rates  
 18               will be based on the Prospective Payment System  
 19               under this title and 75 percent will remain based  
 20               upon reasonable cost reimbursement.

21               (2) For the second year that the provisions of  
 22               this title are in effect, 50 percent of the payment  
 23               rates will be based on the Prospective Payment Sys-  
 24               tem under this title and 50 percent based upon rea-  
 25               sonable cost reimbursement.



1           (3) For the third year that the provisions of  
 2           this title are in effect, 75 percent of the payment  
 3           rates will be based on the Prospective Payment Sys-  
 4           tem under this title and 25 percent based upon rea-  
 5           sonable cost reimbursement.

6           (4) For the fourth year that the provisions of  
 7           this title are in effect and for all subsequent years,  
 8           the payment rates will be based solely on the Pro-  
 9           spective Payment System under this title.

10 **SEC. 617. EFFECTIVE DATE; INCONSISTENT PROVISIONS.**

11           (a) EFFECTIVE DATE.—The provisions of this title  
 12           shall take effect on October 1, 1998.

13           (b) INCONSISTENT PROVISIONS.—The provisions  
 14           contained in this title shall supersede any other provisions  
 15           of title XVIII or XIX of the Social Security Act (42  
 16           U.S.C. 1395 et seq. 1396 et seq.) which are inconsistent  
 17           with such provisions.

18 **TITLE VII—TELEMEDICINE**

19 **SEC. 701. INTERNET ACCESS FOR HEALTH CARE PROVID-**  
 20 **ERS FOR RURAL AREAS.**

21           (a) IN GENERAL.—Paragraph (1) of section 254(h)  
 22           of the Communications Act of 1934 (47 U.S.C. 254(h))  
 23           is amended by adding at the end the following:

24                               “(C) INTERNET ACCESS FOR HEALTH  
 25                               CARE PROVIDERS FOR RURAL AREAS.—In order

1 to meet the objective of providing health care  
2 services in rural areas, the Commission shall  
3 adopt rules to require that telecommunications  
4 carriers provide access to the Internet or other  
5 interactive computer service which is necessary  
6 for the provision of health care services de-  
7 scribed in subparagraph (A) at rates as de-  
8 scribed in that subparagraph. Such access shall  
9 include the infrastructure and bandwidth nec-  
10 essary for the provision of such services. In  
11 adopting such rules, the Commission shall per-  
12 mit a telecommunications carrier to reduce the  
13 amount of its contribution to the mechanism to  
14 preserve and advance universal service by the  
15 amount, if any, by which the rates for providing  
16 access under this subparagraph are exceeded by  
17 the rates for similar access provided to other  
18 customers in comparable rural areas in the  
19 State concerned.”.

20 (b) DEFINITIONS.—Paragraph (5) of such section is  
21 amended by adding at the end the following:

22 “(D) INTERNET.—The term ‘Internet’ has  
23 the meaning given to it in section 230(e)(1).

1 “(E) INTERACTIVE COMPUTER SERVICE.—

2 The term ‘interactive computer service’ has the  
3 meaning given to it in section 230(e)(2).”.

4 (c) CONFORMING AMENDMENT.—The subsection  
5 heading of such section is amended to read as follows:

6 “(h) TELECOMMUNICATIONS SERVICES AND  
7 INTERNET ACCESS FOR CERTAIN PROVIDERS.—”.

8 **SEC. 702. COMMISSION ON TELEMEDICINE.**

9 (a) ESTABLISHMENT OF COMMISSION.—

10 (1) ESTABLISHMENT.—There is established a  
11 commission to be known as the Commission on Tele-  
12 medicine (in this section referred to as the “Com-  
13 mission”).

14 (2) MEMBERSHIP.—

15 (A) COMPOSITION.—The Commission shall  
16 be composed of 15 members of whom—

17 (i) 12 shall be appointed by the Sec-  
18 retary, subject to subparagraph (B); and

19 (ii) 3 shall be appointed by the Sec-  
20 retary from among employees within ap-  
21 propriate divisions of the Department of  
22 Health and Human Services.

23 (B) PROHIBITION.—The members of the  
24 Commission appointed under subparagraph

1           (A)(i) may not be employees of the Federal  
2           Government.

3           (C) DATE.—The appointments of the  
4           members of the Commission shall be made not  
5           later than 90 days after the date of enactment  
6           of this Act.

7           (3) PERIOD OF APPOINTMENT; VACANCIES.—  
8           Members shall be appointed for the life of the Com-  
9           mission. Any vacancy in the Commission shall not  
10          affect its powers, but shall be filled in the same  
11          manner as the original appointment.

12          (4) INITIAL MEETING.—Not later than 30 days  
13          after the date on which all members of the Commis-  
14          sion have been appointed, the Commission shall hold  
15          its first meeting.

16          (5) MEETINGS.—The Commission shall meet at  
17          the call of the Chairperson.

18          (6) QUORUM.—A majority of the members of  
19          the Commission shall constitute a quorum, but a  
20          lesser number of members may hold hearings.

21          (7) CHAIRPERSON AND VICE CHAIRPERSON.—  
22          The Commission shall select a Chairperson and Vice  
23          Chairperson from among its members.

24          (b) DUTIES OF THE COMMISSION.—

1           (1) STUDY AND RECOMMENDATIONS.—The  
2       Commission shall conduct a thorough study of and  
3       develop recommendations on all matters relating to  
4       which telemedicine services should be covered under  
5       the medicare program under title XVIII of the So-  
6       cial Security Act (42 U.S.C. 1395 et seq.).

7           (2) REPORT.—Not later than 1 year after the  
8       date of enactment of this Act, the Commission shall  
9       submit a report to the President and Congress con-  
10      taining a detailed statement of the findings and con-  
11      clusions of the Commission, together with the Com-  
12      mission's recommendations for such legislation and  
13      administrative actions as the Commission considers  
14      appropriate.

15      (c) POWERS OF THE COMMISSION.—

16           (1) HEARINGS.—The Commission may hold  
17      such hearings, sit and act at such times and places,  
18      take such testimony, and receive such evidence as  
19      the Commission considers advisable to carry out the  
20      purposes of this section.

21           (2) INFORMATION FROM FEDERAL AGENCIES.—  
22      The Commission may secure directly from any Fed-  
23      eral department or agency such information as the  
24      Commission considers necessary to carry out the

1 provisions of this section. Upon request of the Chair-  
2 person of the Commission, the head of that depart-  
3 ment or agency shall furnish that information to the  
4 Commission.

5 (3) POSTAL SERVICES.—The Commission may  
6 use the United States mails in the same manner and  
7 under the same conditions as other departments and  
8 agencies of the Federal Government.

9 (4) GIFTS.—The Commission may accept, use,  
10 and dispose of gifts or donations of services or prop-  
11 erty.

12 (d) COMMISSION PERSONNEL MATTERS.—

13 (1) COMPENSATION.—Members of the Commis-  
14 sion shall receive no additional compensation by rea-  
15 son of their service on the Commission.

16 (2) TRAVEL EXPENSES.—The members of the  
17 Commission shall be allowed travel expenses, includ-  
18 ing per diem in lieu of subsistence, at rates author-  
19 ized for employees of agencies under subchapter I of  
20 chapter 57 of title 5, United States Code, while  
21 away from their homes or regular places of business  
22 in the performance of services for the Commission.

23 (3) STAFF.—

24 (A) IN GENERAL.—The Chairperson of the  
25 Commission may, without regard to the civil

1 service laws and regulations, appoint and termi-  
2 nate an executive director and such other addi-  
3 tional personnel as may be necessary to enable  
4 the Commission to perform its duties. The em-  
5 ployment of an executive director shall be sub-  
6 ject to confirmation by the Commission.

7 (B) COMPENSATION.—The Chairperson of  
8 the Commission may fix the compensation of  
9 the executive director and other personnel with-  
10 out regard to the provisions of chapter 51 and  
11 subchapter III of chapter 53 of title 5, United  
12 States Code, relating to classification of posi-  
13 tions and General Schedule pay rates, except  
14 that the rate of pay for the executive director  
15 and other personnel may not exceed the rate  
16 payable for level V of the Executive Schedule  
17 under section 5316 of that title.

18 (4) DETAIL OF GOVERNMENT EMPLOYEES.—  
19 Any Federal Government employee may be detailed  
20 to the Commission without additional reimbursement  
21 (other than the employees regular compensation),  
22 and that detail shall be without interruption or loss  
23 of civil service status or privilege.

1           (5) PROCUREMENT OF TEMPORARY AND INTER-  
2           MITTENT SERVICES.—The Chairperson of the Com-  
3           mission may procure temporary and intermittent  
4           services under section 3109(b) of title 5, United  
5           States Code, at rates for individuals which do not  
6           exceed the daily equivalent of the annual rate of  
7           basic pay prescribed for level V of the Executive  
8           Schedule under section 5316 of that title.

9           (e) TERMINATION OF THE COMMISSION.—The Com-  
10          mission shall terminate 90 days after the date on which  
11          the Commission submits its report under subsection  
12          (b)(2).

13          (f) APPROPRIATIONS.—The Secretary shall provide to  
14          the Commission, out of funds otherwise available to the  
15          Secretary, such sums as are necessary to carry out the  
16          purposes of the Commission.

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